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COMMISSION OF INQUIRY
INTO THE
NON-MEDICAL USE OF DRUGS

COMMISSION D'ENQUETE
SUR L'USAGE DES DROGUES
A DES FINS NON MEDICALES

February 21, 1970
Lecture Theatre
Confederation Centre
Charlottetown,
Prince Edward Island.

COMMISSION OF INQUIRY
INTO THE
NON-MEDICAL USE OF DRUGS

COMMISSION D'ENQUETE
SUR L'USAGE DES DROGUES
A DES FINS NON MEDICALES.

BEFORE:

Gerald LeDain	Chairman,
Ian Campbell,	Member,
J. Peter Stein,	Member,
H.E. Lehmann, M.D.,	Member,
James J. Moore,	Executive Secretary,
Marie-Andree Bertrand,	Member.

SECRETARY TO THE CHAIRMAN:

Vivian Luscombe.

February 21, 1970
Lecture Theatre,
Confederation Centre,
Charlottetown,
Prince Edward Island.

1 ---Upon commencing at 9:35 a.m.

2 THE CHAIRMAN: Ladies
3 and gentlemen, I call this hearing of the
4 Commission of Inquiry into the Non-Medical
5 Use of Drugs to order. I would like to
6 introduce the members of the Commission.

7 On my far right, Dean Ian
8 Campbell, of Montreal; on my immediate right,
9 Dr. Heinz Lehmann of Montreal; I am Gerald
10 LeDain, on my left, Mr. James Moore, executive
11 secretary of the Commission; on Mr. Moore's
12 left, Professor Marie-Andrée Bertrand of
13 Montreal, on Miss Bertrand's left, J. Peter
14 Stein of Vancouver.

15 I should like to read a
16 statement about the background of the
17 Commission's appointment and its terms of
18 reference, and how the Commission interprets
19 its task.

20 The Commission of Inquiry
21 into the Non-Medical Use of Drugs was
22 appointed by the federal government on May 29th,
23 last year, upon the recommendation of the Honourable
24 John Munro, Minister of National Health and
25 Welfare.

26 The Commission has an
27 independent status under Part I of the
28 Inquiries Act.

29 The concern which gave rise
30 to the appointment of the Commission is described

1 in Order in Council P.C. 1969-1112, which authorized
2 the appointment in the following words:

3 "... there is growing
4 concern in Canada about the non-medical use
5 of certain drugs and substances, particularly
6 those having sedative, stimulant,
7 tranquilizing or hallucinogenic properties,
8 and the effect of such use on the individual
9 and the social implications thereof:

10 ... within recent years there has developed
11 also the practice of inhaling of the fumes
12 of certain solvents having an hallucinogenic
13 effect, and resulting in serious physical
14 damage and a number of deaths, such
15 solvents being found in certain household
16 substances. Despite warnings and
17 considerable publicity, this practice
18 has developed among young people and can
19 be said to be related to the use of drugs for
20 other than medical purposes.

21 ... certain of these drugs and substances
22 including lysergic acid diethylamide,
23 LSD, methamphetamines, commonly referred
24 to as 'Speed', and certain others, have
25 been made the subject of controlling or
26 prohibiting legislation under the Food and
27 Drugs Act, and cannabis, marijuana, has been
28 a substance, the possession of or trafficking
29 in which has been prohibited under the
30 Narcotics Control Act;

1 ... notwithstanding these measures and
2 the competent enforcement thereof by the
3 R.C.M. Police and other enforcement bodies,
4 the incidents of possession and use of these
5 substances for non-medical purposes, has
6 increased and the need for an investigation
7 as to the cause of such increasing use
8 has become imperative."

9 In announcing the Commission's
10 appointment, the Minister of National Health and
11 Welfare, spoke of the 'grave concern felt by the
12 government at the expanding proportions of the use
13 of drugs and related substances for non-
14 medical purposes."

15 The terms of reference defining
16 the Commission's inquiry into the non-medical
17 use of psychotropic drugs and substances mention
18 sedatives, stimulants, tranquilizers and hallucinogens.

19 For the present, the
20 Commission understands "drug " to mean any
21 substance which chemically alters structure or
22 function in the living organism, and
23 "psychotropic" drugs as those which alter
24 sensation, feeling, consciousness and psychological
25 or behavioural functions. The Commission has
26 tentatively defined "medical use" in terms of
27 generally accepted medical practice -- under
28 medical supervision or not. All other use
29 is "non-medical use".
30

1 By itself, a prescription
2 does not distinguish medical from non-medical
3 use. A non-prescription drug like aspirin
4 may be taken for medical use. Or a prescription
5 drug may be taken for generally accepted
6 medical reasons, then no longer required.

7 The Commission is invited
8 by its terms of reference to "marshal ... the
9 present fund of knowledge concerning the non-
10 medical use of sedative, stimulant, tranquilizing
11 hallucinogenic and other psychotropic drugs
12 or substances."

13 But since an interim
14 report is expected early this year, and a final
15 report within two years, the Commission will
16 have to be selective.

17 It must consider what appear
18 to be the principal issues which led to its
19 appointment.

20 The Commission has the initial
21 impression that its primary focus must be on the
22 non-medical use of drugs by the young and by
23 adults as it relates to or affects the use of
24 drugs by youth.

25 The Commission has drawn up a
26 preliminary classification of psychoactive
27 drugs, which falls into the following eight
28 categories: hypnotics-sedatives, stimulants;
29 psychedelic-hallucinogenics; opiates-narcotics,
30 volatile solvents and gases; analgesics (non-

narcotic painkillers); clinical anti-depressants and major tranquilizers.

The Commission sees its primary emphasis on the following categories:

1. The psychedelic-hallucinogenic which includes cannabis (marijuana and hashish), LSD and mescaline and the other 'restricted drugs' placed under the new schedule J of the Food and Drug Act: DMT, STP, (DOM), and DET;
2. the stimulants, including such amphetamines as benzadrine and methadrine -- generally referred to as 'speed'.
3. the volatile solvents and gases -- often referred to as 'delirients', such as glue, nailpolish remover, and paint thinner.
4. the sedative-hypnotics, such as the barbiturates (used as sleeping pills), the minor tranquilizers, and ethyl alcohol.
5. the opiate-narcotics, such as heroin.

Alcohol and nicotine are clearly mood-modifying drugs used for non-medical reasons and therefore within the terms of reference. However, the Commission could not possibly perform its task if it were required to consider the extensive research carried out on these substances. A realistic

1 view compels the Commission to regard the
2 non-medical use of alcohol and nicotine in
3 their relation to the non-medical use of
4 other psychotropic drugs. This is also the
5 Commission's position, at least initially,
6 on the non-medical use of the opiate-narcotics,
7 such as heroin.

8 These so-called "hard drugs"
9 are not excluded from the terms of reference,
10 because they do have psychotropic properties.
11 But as with alcohol and nicotine, the
12 Commission cannot hope to do justice to the
13 extensive literature on the subject. The
14 "hard drugs" are therefore to be examined in
15 their possible relationship to the non-medical
16 use of the "soft drugs".

17 Two contentions brought to the
18 Commission's attention may illustrate what is meant
19 by "relationship" to the non-medical use of soft
20 drugs.

21 The first contention is
22 that extensive social use of alcohol not only
23 creates a permissive climate of drug use,
24 but also reflects a provocative injustice
25 and even hypocrisy in our legislative and law
26 enforcement attitudes. The second
27 contention is that the use of certain soft drugs
28 like cannabis (marijuana) leads very often
29 if not generally, to hard drug addiction.

30 What are the issues in this

1 inquiry? The Commission must investigate
2 the extent of the non-medical use of mood-
3 modifying drugs in Canada. That means the pattern
4 of drug use; the drugs and various groups or
5 populations involved, according to age,
6 occupation, etc.; the movement from one drug
7 to another.

8 The Commission must investigate
9 physical and psychological effects of these
10 drugs, effects on behaviour of the
11 individual concerned, effects on others, and
12 effects on society. Finally, and by no means
13 least important, the Commission must investigate
14 the reasons for the non-medical use of drugs --
15 not only the personal reasons or motivation, but the
16 social, educational, economic, philosophic and other
17 reasons. In other words, what is the meaning
18 or larger significance of this phenomenon?
19 What is the true nature of the challenge it
20 presents to our civilization?

21 We have accepted a very
22 difficult task and we need your help. It is
23 imperative that we have the views of as many
24 Canadians as possible. This is not solely a
25 technical question for experts, it is a broad
26 social issue, going to the very nature of human
27 existence in our time. It is a question to
28 which everyone can contribute a measure of
29 insight and wisdom. Please come forward
30 and assist us with your views.

I should say a word about our method of procedure in these public hearings. We receive formal submissions, written, oral and people who make them are seated at this table and there is an opportunity for questions and comments on the submissions by the members of the Commission and some others who are present, and we have encouraged across Canada the widest possible public discussion and we have had a very fine response and I hope you will feel very free this morning to give us the benefit of your views.

We ask people who find it convenient to use these microphones here, one in each aisle. In these public hearings we are not looking for particular details of individual experience. We don't want anyone to identify themselves or their own particular experience in any way, or in any way incriminate themselves. We are interested in what the people know and understand about this phenomena and can be passed on. We do invite people, if they wish, to speak to us privately and give testimony anonymously. We are empowered to withhold the identity of witnesses, so if there is anyone who would like to speak to us privately at the end of our hearing today, we will be glad to speak to them.

1 Now, we have a schedule of
2 briefs, and I call now upon Mrs. Frank Ross, and
3 others representing the Women's Institute of
4 Prince Edward Island. I think Mrs. Ross would
5 like to be seated at the table here.

6 Mrs. Ross?

7 MRS. ROSS: Mr. Chairman,
8 I will take a few words from your submission
9 and use this as our reason for being present
10 this morning.

11 You said that you would offer
12 anyone ^{could} who/contribute a measure of insight
13 to accept the invitation to feel free to
14 express opinions, and as a member of the Women's
15 Institute of Prince Edward Island,
16 representing our provincial board, this is all
17 we should be able to do this morning. Had
18 the information came to us at a much earlier time,
19 our organization would be very happy to have
20 presented a fully documented brief. But
21 you readily understand that to have the
22 facts and figures for this would have meant
23 much more time to spend than the two weeks
24 advance notice that we received. Incidentally,
25 quite by accident.

26 Perhaps even the
27 attendance here this morning is not indicative
28 of the interest over the Island, but perhaps
29 reflects either the feeling that, and I don't
30 mean this in any derogatory way, we have

1 been commissioned to death in Prince Edward
2 Island, but it is a lack of communication perhaps
3 that I think symbolizes the whole of the
4 problem as we see it. It is a breakdown
5 and lack of communication all along the line;
6 you can call it what you like.

7 I know that the interest
8 far exceeds the level of the interest
9 indicated by the number of organizations
10 represented this morning. We don't want you
11 to feel that there is in any way a lack of
12 concern, although there is a grave lack of
13 concern and while our organization represents
14 a cross-section of all people on the Island,
15 I feel that individually we would have been
16 reflecting opinions from churches or law
17 or welfare agencies and more particularly
18 as parents and those interested especially
19 in young people.

20 I think that our biggest
21 problem that we have felt as an organization
22 or as individuals, is the absolute lack of
23 knowledge that we feel is necessary to evaluate
24 the situation. There have been articles in
25 the newspapers; there have been panels on
26 television; there have been comments on radio,
27 and yet you hear just so-called experts in their
28 field giving absolutely contradictory reports,
29 and to the layman this can't help but be
30 contradictory and can become very confusing.

1 that those people should have a sense of
2 responsibility and integrity and I realize
3 that these are more or less dirty words in
4 some vocabularies, now they have possibly gone
5 to extinction, have to be brought back into the
6 right perspective. We have to realize that
7 somewhere along the line, someone is going to have
8 to make a stand and stop long enough to analyse
9 it. It is a lack of medical knowledge
10 perhaps, a lack of testing. We think that
11 things are going to be for the benefit of
12 mankind, to help us turn out that way.
13 The thalidomide babies are living evidence
14 of a drug that they thought was right and yet
15 ends up wrong.

16 Things that we have accepted
17 for a long time, the use of phosphates in
18 fertilizers. We welcome as housewives
19 the addition of enzymes to our soaps and
20 detergents, only to discover now that they
21 add to our pollution. It is quite easy to
22 make headlines. Last week (unintelligible)
23 on a stick, /the long, black, greasy, slimy, sticky/^{mess} that was
24 threatening our shores, and within a few
25 hours to have the whole area practically
26 mobilized in its defence.

27 This is something they could
28 see, this is something they could feel, and
29 something they could smell because it was
30 something that was going to touch them and they

1 were going to fight against, and even in the
2 light of the legislature of Nova Scotia,
3 they are promising so many millions of
4 dollars to mop up the damage.

5 But the damage caused by
6 drugs and the things that have affected our
7 youngsters is not something that you can see
8 and feel and look at, for the simple reason
9 that many of these things have become family
10 skeletons. The youngster in our hospital
11 whose mind is permanently damaged because he
12 sniffed glue and he was just young, and there
13 are those who will always be there because they
14 have had a stronger and more glorious trip, shall
15 we say? These are the things that people don't
16 talk about. The general public aren't aware of
17 this, and of course, it happened to somebody else,
18 it didn't happen to me, so it is no business of
19 mine, anyway.

20 So that I don't have to talk
21 to my politician about it, I am not that concerned,
22 I am more worried about the mile of pavement that
23 needs to come down or the personal commodity than
24 I am the road that this young drug addict might
25 eventually take, or the price that we all
26 have to pay in his rehabilitation or in
27 his future care. We have no proof that any
28 of these so-called harmless drugs are really
29 harmless, and we say, well, perhaps one
30 drink doesn't make an alcoholic, one sniff

1 doesn't make an addict. This is quite true,
2 but what about the picture of accumulation
3 over the years, and it has been shown and I
4 believe that other briefs will show its
5 truthfulness and hard facts that we have not
6 been able to deal with. But we have no
7 proof what for the next ten years, even for
8 an ordinary user of drugs, even for those
9 who have not turned to hard drugs, the problem
10 has not been with us long enough to make
11 a concrete evaluation. And we, as an
12 organization in the short time that we have
13 been able to make just the recommendation
14 we have, we are, as a group, solidly opposed
15 to any legalization of the sale of marijuana
16 as has been suggested, because we feel that
17 it is not a step to be taken lightly or ill-
18 advisedly, unless a lot - - more research,
19 very very carefully documented, is produced
20 over a long time, before any step like this
21 should be taken. And also, the non-
22 medicinal use of drugs which would come under
23 the Drug Act by those that are issued
24 by prescription, more insistence on the time
25 the prescription which is not up for renewal
26 unless prescribed by the doctor, would do away
27 with some of the effects such as the mis-use
28 of tranquilizing drugs or drugs within that
29 area.

30 And again, the third thing

1 we would ask is that the information that
2 goes to the public, there has been a tremendous
3 campaign against smoking and the prevention
4 of lung cancer, the powers that can get
5 behind a movement like this; we can say
6 that immediately things cannot come off the
7 market but in any event any news media
8 give a very true and very, very careful picture
9 and not so much the accent of the positive
10 glories of the drugs and the habit.

11 I know that more and more it becomes difficult
12 to make a by-line or a headline that is going
13 to touch the readers attention and this
14 perhaps leads to the over-accenting of smaller
15 items, just for the sake of drugs and
16 making them sensational.

17 That, I think briefly, and
18 I would thank you for your permission to
19 explain a few points of view that we have,
20 I am saying again that we are extremely
21 interested in anything that we would hope
22 as an organization devoted to our home and
23 country, this touches us all, and we are
24 interested in information and dissimulation
25 of correct absolute information to our boys
26 and girls, to our parents -- particularly to
27 our parents who feel that they need to know
28 more about this, and be able to recognize the
29 problem if it's present and where do we go
30 and what do we do? Where can we help?

1 We feel there are reasons behind it,
2 perhaps if I were a sociologist I could speak
3 with some authority and put my feelings down
4 into words, but that is an area for someone
5 else. Thank you.

6 THE CHAIRMAN: Thank you,
7 Mrs. Ross. Would you tell me what the
8 Womens Institute is exactly, its composition
9 and role?

10 MRS. ROSS: The constitution
11 of the Womens Institute of Prince Edward Island
12 is we have small groups gathered over the
13 Island, it is not political.

14 THE CHAIRMAN: Is it
15 voluntary?

16 MRS. ROSS: It is a voluntary
17 organization and it is a model for home and
18 country, dedicated to leadership.

19 THE CHAIRMAN: Can anyone
20 join it?

21 MRS. ROSS: Anyone may
22 join. It has no bias as to religion, creed
23 or colour.

24 THE CHAIRMAN: How many
25 members do you have?

26 MRS. ROSS: We have
27 approximately four thousand on the Island.
28 We belong to the national body of Federated
29 Institutes of Canada and through that, belong
30 to the Associated Country / of the World, seven
Women

1 and a half million members around the world.

2 THE CHAIRMAN: Do you have
3 any organization internally with any character
4 exactly for developing your policy on drug use?
5 How would you develop these views? Are these the
6 views for the Institute of P.E.I.?

7 MRS. ROSS: This starts at
8 the local branch at the community level, where
9 large groups are joined together and from our
10 district areas and then we have a provincial board.
11 Does this answer your question?

12 THE CHAIRMAN: Yes, and then
13 how do you develop your policies on drug use?
14 Have you had discussions ---

15 MRS. ROSS: We have had
16 discussions within small groups. If there had
17 been more time, this would have come as a formal
18 resolution from some small groups in the district
19 area, presented at a district area convention, a
20 group of 50 conventions, which would have been
21 supported at the provincial convention held in July,
22 and then brought before the full board. In this
23 case, in the urgency of it, it had to be with the
24 consent of the members of the board, and the conveners
25 who represent the whole province. This is why we
26 could not make a formal brief.

27 MR. STEIN: Mrs. Ross, I
28 wonder if you could tell me whether or not
29 your organization has any views regarding the
30 present policy of sending persons who are users

1 of illegal drugs to prison.

2 MRS. ROSS: Our organization
3 would have individual views, but as such, we
4 haven't -- and I cannot express an opinion for
5 our collective views, because this has not been
6 passed through the board. We would have been happy
7 to do this had we had the time, but our format,
8 going through the grassroot members, would not
9 give us time in this situation.

10 MR. STEIN: Would you
11 care to comment as a private individual on
12 that?

13 MRS. ROSS: I would like to,
14 except I am here as the vice-president of the
15 provincial board and would be associated
16 directly with the Womens Institute. It is
17 rather difficult to divorce oneself from the
18 organization in this instance.

19 THE CHAIRMAN: Mrs. Ross,
20 you referred to the need for information, of the
21 dissemination of correct, absolute information for
22 parents. But you also commented, if I understood
23 you, on the glorification of allegedly positive
24 aspects of drug use.

25 MRS. ROSS: Unfortunately,
26 perhaps the preponderance of information
27 reaching our young people today has been
28 lacking.

29 THE CHAIRMAN: Yes. The
30 question we have been asking recently

1 in respect to drug information
2 and drug education is whether, it is
3 agreed that positive aspects if they
4 exist, should
5 be conveyed as well as the negative aspects.
6 We repeatedly hear that we must have more
7 information, more research, and more information
8 must have the truth, the whole truth about the
9 drugs and this has been the theme across
10 Canada, and we have been recently asking the
11 question in our hearings, whether it is agreed
12 that positive as well as negative aspects must
13 be conveyed, and I just wondered what your
14 views of that are in the light of your comments?

15 MRS. ROSS: You do need
16 both sides of the question but anyone who has
17 dealt with mass media ^{been} or/ exposed to it as
18 we all have, you know there are different ways
19 of making up a statement, and even the
20 personality of the person who makes it, or their
21 appearance, can weigh the matter pro and con.
22 In a way it is not relevant, and yet it has
23 some objectivity perhaps/ ^{that} at the time that John F.
24 Kennedy was elected to the presidency, they
25 said the appearance of the contestants on the
26 television screen won that election.

27 Now this is the same thing,
28 in a program of this sort, especially ^{if} it is
29 visual instead of auditory, where the impact of the
30 persons, their personality, their appearance

1 and even their choice of words give certain
2 bias to the message that people don't really
3 realize.

4 PROFESSOR BERTRAND: How
5 do we know that it is biased?

6 MRS. ROSS: I didn't say
7 biased. You misinterpreted me. I said it
8 gives a -- slant, shall I say, to anyone
9 listening, it is like the package of the product
10 that gives you a bias toward buying it. You are
11 thinking of bias as prejudice against the statement.

12 THE CHAIRMAN: Have you
13 any ideas, Mrs. Ross, as to how
14 we should go about establishing information
15 that we are going to use in the drug education
16 program, that might establish the kind of
17 educational materials we are going to make
18 out of the information and generally how should
19 we distribute the responsibility for making
20 this presentation?

21 MRS. ROSS: According to
22 the constitution it will have to be determined
23 provincially, you see, if it comes under the
24 educational field. It has to be made
25 available, but it would not be a must.

26 THE CHAIRMAN: No, but
27 would you envisage the possibility of the
28 federal government or the federal government's
29 responsibility, to establish the information
30 data through research and the evaluation and so on

1 and make it available at the provincial level?

2 MRS. ROSS: Well, this
3 after all, the Department of National Health
4 and Welfare does a terrific amount, really
5 excellent research in bringing information down
6 and this is an accepted channel but
7 it wouldn't necessarily be used in the same way.

8 THE CHAIRMAN: The reason
9 I am following this line of questioning, is
10 the importance you attach to the matter in which
11 this is presented and I am wondering if you
12 have any views as to how that should be
13 organized, or should we just leave it to
14 individual sense of responsibility using such
15 good material as one can lay one's hands on,
16 or that is available or should there be a kind
17 of a community attempt to assume this
18 responsibility in a way that would satisfy
19 your concerns, for example, about the general
20 way it is presented and so on?

21 I wonder if you have given
22 any thoughts to that, because these comments are
23 important.

24 MRS. ROSS: We haven't
25 had time to pursue it much further. It had
26 arrived at quite a good point in our discussion
27 at the time, but we would have been able to
28 give perhaps more detailed expression on it.
29 We haven't had time to pursue it further.

30 THE CHAIRMAN: I hope we

1 didn't -- we apologize to the Women's Institute
2 for not having included them in our original
3 mailing list in the fall. We sent out
4 notices to over seven hundred and fifty individuals and
5 organizations and it was an omission on our
6 part and you received of course, two weeks
7 ago, local advertisement of our hearings.

8 MRS. ROSS: Actually, no,
9 it was the Chairman -- Dean of Arts at the
10 University of P.E.I. that told me.

11 THE CHAIRMAN: I hope
12 we will still^{have}/ the benefit of any further
13 views that the Institute may develop.

14 MRS. ROSS: We would be
15 very happy. We did have last year when we had a
16 drug hearing in Prince Edward Island or the
17 workshop, call it what you will, we had
18 representation there at that time, and we are
19 very very interested in getting whatever
20 information is available, in any areas and
21 keeping in close contact in exploring the
22 problem. We want to work with and for our
23 young people.

24 THE CHAIRMAN: Thank you
25 very much, Mrs. Ross.

26 Are there any questions
27 or comments?

28 Now, I would like to call
29 upon the Attorney General of Prince Edward
30 Island, the Honourable J. Elmer Blanchard.

Mr. Blanchard? Is that
the right pronunciation?

Justement, est-ce que
vous parlez Francais?

MAITRE J. ELMER BLANCHARD:
Procureur general de L'ile du Prince Edouard:

Oui, un peu.

Mr. Chairman, and members
of the Commission, I have been asked by the
Premier of the Province to extend to you
a very warm welcome to the shores of Prince
Edward Island, and also to extend those greetings
on behalf of my colleagues in the government.
We trust that your stay here in Prince Edward
Island will be pleasant, and that the
representations made to you today will be of
particular value to the findings of your
Commission.

I wish to state also, Mr.
Chairman, that I appear here in an official
capacity as Attorney-General and also as
a family person, interested in the future of
my children and the children of my neighbours.

And with your permission
I would proceed to the formal brief that
has been prepared.

I welcome the opportunity
of presenting a brief to this Royal Commission
on the question of drug use in Canada.

We have sought to investigate the extent of drug

1 use on Prince Edward Island. Since this
2 is also a national matter, and I must speak
3 responsibly as a member of the Provincial
4 Cabinet, which has fully and without equivocation
5 backed this presentation. We have also
6 sought the best possible up-to-date and
7 accurate information for the purpose of
8 making recommendations on federal government
9 policies. The extent to which drug use
10 has developed on the Island is not altogether
11 clear. We have the impression ^{from} high school
12 youth and other information that marijuana
13 is available to those who seriously seek
14 it. We understand also that quite a small
15 percentage of our Island youth are involved
16 in drug taking of any kind, not including the
17 use of alcohol.

18 In view of the fact that
19 the Alcohol Foundation is presenting a brief
20 I will not deal with the question of alcohol,
21 but confine myself to the certain aspects of
22 other drug usage. We also accept the fact
23 that in American cities and many Canadian
24 cities drug use is on the increase. Some
25 believe in epidemic proportions. But we
26 also believe it is not yet as widespread
27 among Canadian youth as the impression is
28 often given. We have noted with grave
29 concern the growing evidence of the dangerous
30 and explosive nature of drugs such as

1 LSD. The picture of a brilliant twenty-one
2 year old Toronto musician found on February 2nd
3 of this year, on a street corner, with a finger
4 shoved into each eye socket, endeavouring to
5 tear out his eyes to prevent him from seeing the
6 awful image visualized on a bad LSD trip
7 shocks the imagination. His successful
8 attempts at blinding himself adds to the
9 horrors caused by the Tate murders in Los
10 Angeles. And earlier this week the murder
11 of a North Carolina doctor's wife and two small
12 children by a group shouting the horrendous
13 slogan, "Acid is groovy; kill the pigs".

14 The increasing evidence that
15 LSD, the speeds and other drugs are highly
16 dangerous in the Russian Roulette manner
17 points clearly to the fact that under no
18 circumstances should these be made more
19 easily available and that speedy consideration
20 must be given to the question of restricting
21 their use more firmly by this Commission and
22 the federal government.

23 I am personally aware of
24 a responsible professional person who left a
25 major city in the United States to live in a
26 small community because his six and seven
27 year old children have become exposed in their
28 school situation to the use of drugs. Some
29 youngsters of this tender age were returning
30 high or sick from drugs.

The Montreal Gazette item from New York on January 3rd, 1970, describing the tragedy of the twelve year old daughter of a New York Psychiatrist who had become hooked on drugs through friendships in her group adds to our concern. She had just returned to her home from a three day misadventure in the drug jungles of the city where she remained totally under the influence of drugs, such as LSD, amphetamines and mescaline. The tragedy of this innocent addict has caused her parents to take her from the nation to escape the problem.

Our intention today is to dwell at length on the question of marijuana. We are conscious that a society must always seek to protect itself and its future against actions which would tend to destroy the general good of society. As a result a problem is frequently created between the rights to personal freedom and the good of society as a whole. A government must legislate with a view to the general good of society with as little interruption of personal freedom as is required to preserve the general good.

Legislation in a very basic sense also puts a stamp of approval, or, if you will, gives moral assent to an action in the minds of the general public. Great caution is therefore required to meet these

1 difficult balances and responsibilities. There-
2 fore, in preparation for the visit of your Commission
3 it was important that the latest possible authori-
4 tative information be obtained so that any position
5 taken would have an authoritative backing.

6 The information obtained was
7 then made available to high ranking medical and
8 other professional people associated with the
9 government and to responsible bodies in the
10 community. As a result the recommendations
11 of this paper have been backed, not only by
12 the government of Prince Edward Island,
13 but also by our top flight government professional
14 people and a number of responsible groups
15 in the province, some of whom will be making
16 presentations today: The Minister of Health,
17 the Honourable Bruce Stewart; the Deputy
18 Minister of Health, Dr. O. H. Curtis;
19 Dr. Mac Beth, director of Mental Health; Dr. Ian
20 Craig, pathologist of Charlottetown Hospital
21 and director of our laboratories division;
22 Dr. Lemuel Prowse, Chairman of the Prince Edward
23 Island Hospital Services Commission and Chief
24 Coroner; Dr. Kenneth Harper, Superintendent of
25 Charlottetown Schools; Dr. Donald Glendenning,
26 Principal of Holland College; and other educationists
27 are in full accord with our position as well
28 as our police authorities and members
29 of the legal profession in the Attorney General's
30 Department.

Part of the reason for concentration on marijuana is the apparent campaign underway in Canada and other countries to pressure governments into legalizing the drug. We have even noted apparent prejudicial reporting by press, radio and TV mediums stressing the statements of pushers of marijuana and neglecting statements by those opposed to its widespread use or hard evidence of its harmful effects.

For example, when your Commission appeared in Winnipeg last November, a major portion of your day was taken up by the Canadian Crown Prosecutors who dealt with the problems caused by marijuana and the inadvisability of legalizing the drug. C.B.C. TV news, that evening, completely neglected their material, and instead, gave two minutes to a youth who talked about enjoying the drug and quoted from another very brief presentation given by a Winnipeg lawyer recommending legalization of marijuana.

One senior Canadian legal official with whom we are in contact said that we were facing a very powerful lobby representing a small minority who are making themselves felt in government and other circles. It is now time for the feelings of the family people concerned with youth and a general responsible public to be heard with

conviction.

Some people are suggesting that we should look at the whole question without emotion, but the pro drug lobby are making highly emotional appeals. And I ask, how can you be unemotional about the evidence that younger and younger children are being trapped by drug use, and the incident which took place two days ago, for example, when two teenage youths in Montreal grabbed their hostess who had kindly provided them with badly needed food, for a few days, clubbed her unconscious with table legs and tied her up with an electrical wire in her room. Staggering out after regaining consciousness, this eighty-five year old woman was rushed to hospital, suffering from multiple face and head injuries and severe loss of blood. The two youths when captured, reported that they had been stoned out of their minds on hashish, a strong form of marijuana, when they perpetrated the crime.

Equally serious, we were shocked to find that in the last few days that almost no one at medical, legal, university student, professional or school levels on Prince Edward Island were aware of the primary research now available which clarifies a number of harmful and/or dangerous characteristics of marijuana use. Staff and students

questioned from Prince Edward Island educational institutions who had attended at least three major university conferences on drugs in the past eighteen months, came away with no firm impressions whatsoever of harmful effects from marijuana.

One very senior school official said, in fact, that he came away from the recent U.P.E.I. conference with a desire to try marijuana following the presentations. Good communication only occurs when those communicated to really get the point. Although some negative aspects of this drug were casually covered in these presentations, the total effect provided by the speakers was a mild, and I quote, "Don't be concerned about marijuana" attitude. At one conference held at Dalhousie University for the medical profession in December, 1969, doctors came away with similar impressions. A panel on marijuana use, for example, was led by a professional man generally considered sympathetic to its use who interviewed two young users of the drug, who gave very favourable comments. When our information was presented to a university doctor who had been present, he was deeply disturbed at the contrast between reality and the conference impressions.

Some seemingly responsible people want to rush ahead into legislation without waiting until sufficient evidence is fully

1 available. Films like Easy Rider
2 now show^{ing}-/in this city are no help. One
3 concerned young nurse who works with youth
4 reported to us that the film showed in a
5 highly effective manner, the so-called delights
6 of taking drugs and gave no strong impressions
7 of withdrawal problems or other harmful

8
9 A youth who was at all
10 emotionally upset, she reported, would turn to the
11 drug use as an attractive escape after seeing
12 such a film. And tragically, we have
13 found that most of the youth questioned by us
14 believe that marijuana was no worse or even not
15 as bad as alcohol or smoking and certainly
16 non-addictive, although there were some doubts.

17 The time has come to wake
18 up to reality in Canada before it is too late.
19 A few people were astonished to hear that
20 some evidence^{been} has/available for years on the
21 problems of marijuana use, but in the past
22 several weeks a number of the most authoritative
23 persons in the drug research world, have come
24 out with convincing evidence. It is so
25 convincing that it is no longer possible to
26 take a neutral attitude and still be true to
27 certain scientific, medical considerations and
28 to our responsibilities as a government.
29 Our task however, is not to weigh the pros and
30 cons. We recognize^{that} some researchers have found

1 little harm in the use of the drug, in their
2 particular work. But when human health is involved,
3 it is medical practice and social expectation
4 that where some authoritative research does
5 indicate trouble, then the drugs or treatment
6 involved are either stopped completely, such as
7 with the case of thalidomide, or held under
8 strict control until much, much more is known.

9 Let me list the compelling
10 evidence collected: Dr. Stanley S. Yolles,
11 Director of the National Institute of Mental
12 Health in Washington, which is perhaps the
13 prime instigator of research in the drug
14 field on this continent, a few weeks ago
15 reviewed with his research staff the latest
16 available research findings, and I shall quote
17 from his report of February 4, 1970 to the
18 United States House Committee on drug uses:

19 "While stressing that
20 marijuana differs from
21 narcotics", he summarized,
22 I quote, "additional information
23 about marijuana which has
24 resulted from more recent
25 studies in which researchers
26 have learned some troublesome
27 facts in the laboratory and
28 the community which makes it
29 impossible to give marijuana
30 a clean bill of health in any

discussion on the continued
restriction of the use. "

"Marijuana," he continues,
has been found to interfere with the thinking
process and recent memory. It also weakens
the power to concentrate and subtly retards
speech. The drug stimulates anxieties and
guilt feelings and instead of stimulating
conviviality, marijuana can turn a person
inward. Its sometimes pleasurable effects
can be contracted by considerable discomfort.
In high doses the active chemical constituent
of marijuana causes psychotic reactions.

"The long term effects still
have to be determined," Dr. Yolles adds, "but there
is a growing body of evidence that the
continuing user or pot head becomes so involved
in the process of securing and using the drug,
that his drive and motivation towards any
other activity is impaired.

Additionally,^{since} the drug
appears to attract youngsters who already have
emotional problems, it may aggravate those
conditions while removing the youngster from
normally accepted processes of personal
growth." A few of the most thorough and
convincing studies themselves have been
reported to us by a widely recognized
authority, Dr. Donald B. Lauria, President and
Chairman of the Department of Public Health and

Preventive Medicine at the New Jersey College of Medicine and Dentistry in Newark City, where drug usage has become a severe problem; and they are 1. The Keeler Report in diseases of the nervous system 29-314, 1968 states that recurrence, -- and I stress recurrence of unpleasant effects have occurred after taking marijuana.

2. The Isabel study in psychopharmacology, 11-184, 1967 provides evidence that the effect of marijuana is dose related. That is, ^{if} sufficient is taken, you get LSD-like reactions.

3. Dr. Grossman's work in the annals of internal medicine 70-529, 1969 provides studies of Americans using marijuana in India who were found to have panic and psychotic reactions with some panic reactions reported in perfectly normal people.

4. Talbot's study in the Journal of American Medical Association 210-299, 1969 demonstrates acute reactions requiring psychiatric treatment among United States soldiers using a strong variety of marijuana in Viet Nam and finally (Milman's) Research in the Journal of Pediatrics 74 283 1969 reports cases of severe reactions to marijuana among patients with previous emotional problems.

We have also received a

1 report this week from Dr. Henry Brill,
2 Director of Pilgrim State Hospital in New
3 York, former president of the American
4 Psychiatric Association, Chairman of the
5 American Medical Association Committee on Drugs
6 and Alcohol, Chairman of the National Research
7 Committee
8 Council/on Drug Dependence and a member of the
9 World Health Organization Drug Committee.

10 Dr. Brill has categorically
11 stated to us and I quote:"the harm caused by
12 marijuana is not open to question any longer,
13 in view of the latest research available."

14 Dr. Brill has also provided us with a clear
15 statement of the definitive differences
16 between alcohol and marijuana usage, as a
17 counter to the frequently heard defence
18 of marijuana,namely that it is no worse than
19 alcohol. He states 1. Alcohol is

20 primarily a sedative or depressant drug, which,
21 as increasing quantities^{are}taken becomes an
22 anaesthetic, putting the person to sleep.
23 Marijuana on the other hand is a hallucinatory
24 drug which in increasing quantities leads to
25 hallucinations which strengthens with dosage.

26 2. Alcohol has been
27 established in society and society over a long
28 period of time has learned to cope with it,
29 although often poorly. Marijuana is not
30 so established and no pattern for coping
has been developed by society.

3. Western society has accepted alcohol over the long centuries of use, whereas in almost every country, and I repeat, every country where hashish and marijuana has been freely and openly available the Eastern countries have come to stop its free use. India, for example, in 1959 passed national legislation designed to eradicate marijuana use while as far back as the 1920's, Turkey with its long experience of hashish led the move in the old League of Nations to ban hashish and marijuana on a world scale.

4. Because of its instability there is no known method by which the active chemical ingredient of marijuana can be standardized while alcohol can be specifically standardized; and finally, number 5, whereas the response to alcohol can be predicted with very little exception, the human response to marijuana is quite unpredictable.

I would also draw to your attention the judgment and full testimony regarding marijuana use which was given in 1967 before G. Joseph Tauro, chief justice of the superior court of Massachusetts, in the Boston trial of two men ^{caught} / trafficking in the drug. An all-out attempt was made to defend the accused on the basis of the essential harmlessness of marijuana.

In what is considered to be the greatest marshalling of evidence from all over the world up^{to} that time, the Court ruled firmly that marijuana was clearly proved to be a personal and usually harmful drug and the conviction of the two traffickers should stand.

Allow me to quote from the judgment: "It is my opinion based on the evidence presented at this hearing that marijuana is a harmful and dangerous drug. The effects of marijuana are not readily predictable and accentuate the psychological predisposition of the user. As it is commonly used, its only purpose is the induction of a state of intoxication or euphoria. While under the influence of marijuana a person's mental process is disoriented. His perception of time and space is distorted, his co-ordination is impaired, but his strength remains undiminished.

" Marijuana tends to cause the user to lose perspective and to focus his attention on one object to the exclusion of all others."

The judgment continues:

"The drug is of a great attraction for young men and women of college less, during age or/ their formative years, where they should be gaining the education and experience on which to build their future lives.

Furthermore there is widespread emotional instability among the users of marijuana. The use of the drug allows them to avoid the resolution of their underlying problems rather than to confront them realistically.

In addition, users naturally associate with other users who are likely to have emotional problems and compound one another's difficulties. In such a person the use of marijuana may cause temporary psychotic episodes. They develop a drug oriented culture which is marked by a peculiar proselytism whereby users strive to introduce non-users to the drug. Marijuana users customarily use the drug with the specific intent of becoming intoxicated." No evidence was introduced to show any significant number of persons who use marijuana to achieve a state of relaxation short of intoxication.

And continuing the judgment reads: "Marijuana can cause psychological dependence in the user. The user can come to depend on marijuana as a crutch and its use becomes habitual. It is this form of addiction which modern medical experts assert is the proper definition of the term -- the possible dangers associated with its use are clearly discernable --

1 its tendency to reduce inhibitions both
2 verbally and actively and the dependence
3 on its unpredictable effects and the
4 disposition of the user,
5 when used ^{by a} despondent, hostile or unstable
6 person.

7 Its impairment on
8 motor co-ordination coupled with the contention
9 of muscular strength and the distortion of
10 time and space relationships makes its use
11 extremely hazardous among those operating
12 machinery, especially automobiles, and among
13 those individuals responsible for the care
14 and custody of other persons, such as the
15 parents of young children.

16 The propensity of
17 marijuana users to concentrate on one object
18 while ignoring all others, leads to a loss
19 of awareness and frustrates the formation of
20 rational judgments by them. This narrow,
21 subjective preoccupation of users, especially
22 the young, with drugs and their effects, can
23 cause irreputable disruptions of education,
24 family ties or careers, and whose adverse
25 personal and social effects can last long
26 beyond the period of actual marijuana use.
27
28 attention
29 through drug consumption, marijuana users
30 are apt to neglect their own and that of others

1 in their care, and to submit to a life of
2 indolence. The effects of these patterns
3 of living are not limited to the users themselves
4 and society must assume the burden for
5 those taking marijuana. There is no
6 allegation by the Commonwealth, that is, the
7 Commonwealth of Massachusetts, that addiction
8 to hard narcotics, crime and promiscuity
9 would disappear if marijuana use were to disappear.
10 Nevertheless there is abundant evidence that
11 marijuana use is closely associated with these
12 other social evils in a great many instances.
13 The coincidence between addiction to hard narcotics,
14 crime and promiscuity is too great to be passed off
15 as merely accidental. The defendant's answer,
16 the fault lies not with the nature of the drug,
17 but rather with the user and his environment.
18 Admittedly in such complex and intertwined problems,
19 no one factor can be singled out as the sole,
20 efficient cause.

21 Yet it is reasonable in the
22 light of facts now known to conclude that the use
23 of marijuana contributes to hard narcotic
24 addiction, crimes other than those related
25 to the violation of the marijuana laws
26 and sexual promiscuity.

27 Furthermore, if the fault
28 does lie with the instability of the persons
29 prone to use marijuana, it would seem that
30 this fact would lend added support to the

1 laws prohibiting its use."

2
3 The judgment also deals
4 with the comparison frequently made between
5 alcohol and marijuana and states that "... the
6 difference in the legislative treatment of the
7 two substances is reasonable in view of
8 factual differences between them, among which
9 are the facts that alcohol has been in widespread
10 use among the general populations since
11 colonial times. Marijuana use was never
12 widespread among the general population, nor
13 has its use become so ingrained in our
14 culture as to make laws strictly prohibiting
15 its use impractical."

16 "I found the testimony of the
17 experts in various branches of science very
18 illuminating and helpful, although often
19 controversial," commented Judge Tauro.
20 "On the other hand there were areas of
21 agreement among them. Of grave and
22 immediately apparent importance is the growing
23 appeal marijuana has for young people of
24 high school and college age and for those
25 having underlying instabilities or personality
26 disorders of varying degrees. In many
27 instances, the ones least capable of
28 coping with the mind altering effects of the
29 drug are the most likely to be adversely
30 affected by its use. The serious effects
of marijuana superimposed upon mental and

1 personality disorders," he continued, "have
2 been described at length and in great detail
3 by competent experts. I find this testimony
4 persuasive. Actually there is little if any
5 no dispute in this area between the
6 defendant's experts and the Commonwealth's
7 experts."

8 "Further/^{more} in its application
9 to youngsters of high school and college age
10 the problem presented by the use of this drug
11 assume tremendous proportions. "

12 " There is no persuasive
13 evidence that its use produces any beneficial
14 results. Marijuana is likely to be
15 used at least initially as a lark, as an
16 adventure without fear of serious consequences.
17 Thus the first and apparently innocuous
18 step may be taken and a succession of others
19 possibly leading to drastic results."

20 "This phase of the problem
21 is further complicated by those who, unwittingly,
22 and perhaps unintentionally, create the
23 impression that marijuana is harmless
24 because it is not physically addictive.
25 The young seize upon such utterances to
26 rationalize their conduct. There was
27 ample compelling testimony," states the
28 judgment, "that its use causes psychological
29 dependence. Its users may come to resort
30 to it habitually in order to compensate

1 for real or imagined inadequacies or to
2 avoid real or imagined problems. This
3 pernicious and insidious form of addiction
4 is sometimes the first step in the direction
5 of the more potent or physically addictive
6 drugs. It is^a/universally accepted fact
7 that marijuana is a mind-altering drug
8 and generally accepted fact that the drug
9 has no medically recognized therapeutic value.
10 It provides a substantial crutch to its
11 users. It provides a false sense of
12 capability, strength and courage. This is
13 of great importance when the drug user is
14 faced with a problem which demands exercise
15 of judgment and where the drug substitutes
16 a euphoric and unreal feeling of exhilaration
17 for the calm and logical thinking required
18 by the circumstances."

19 The judge then continues:

20 "In place of positive thinking and positive
21 action the user's mind is altered and distorted
22 causing serious interference with his
23 powers of perception and coordination and
24 his ability to judge the passage of time
25 and space. The use of the drug also
26 tends to accentuate any tendency toward
27 improper conduct. In addition, it produces
28 an abnormally^{subjective}/concentration on trivia."

29 "In short, marijuana produces
30 a state which is analogous to a temporary

1 mental aberration. Its prolonged and
2 excessive use may induce a psychotic state,
3 especially in those individuals with
4 pre-existing psychological problems. "

5 "In my opinion," the judge
6 continued, "a proper inference may be drawn
7 from the evidence that there is a relationship
8 between the use of marijuana and the incidence
9 of crime and anti-social behaviour.

10 In any event, there is no indication from the
11 evidence that the user of marijuana becomes,
12 through its use, a better student, a better
13 worker, more dedicated to the public interest
14 or more efficient or productive in any
15 undertaking. On the contrary there is

16 convincing evidence that the converse is
17 true . Many succumb to the drug as
18 a handy means of withdrawing from the inevitable
19 stresses and legitimate demands of society,

20 a manifestation of the selfish withdrawal
21 from society. It is difficult to justify
22 any law which would permit an expansion in
23 the use of marijuana to the point where
24 conceivably it would fall into the same
25 category as alcohol and become a part of
26 our national culture; that the use of
27 marijuana may have results similar to those
28 associated with the abuse of alcohol is hardly
29 a persuasive argument for its legalization.
30 Marijuana users must, of necessity, consort

1 with opportunistic pushers and other hardened
2 members of the criminal element. In the case
3 of youngsters this is especially dangerous.
4 It introduces them to and establishes a rapport
5 with persons whose total influence is apt to
6 be corrupted."

7 "The defendants argue," wrote
8 Judge Tauro, "that the statutes are also primogenic
9 in nature as well as cruel and unusual, in
10 that they prescribe serious criminal penalties
11 for what may be relatively minor offences."
12 These arguments certainly do not apply to
13 pushers. The legislation might profitably be
14 reviewed with regard to the penalties provided
15 for possessors as opposed to pushers, or where
16 the evidence indicates a first offence with
17 the improbability of repetition.

18 In such cases the judge
19 would be given wide discretionary powers so
20 that the imposition of a criminal record may
21 be avoided wherever warranted by the facts.
22 Neither do they present any issue of cruel
23 and unusual punishment. I recommend to you
24 as members of the Commission a thorough
25 research of the evidence of this classic trial.

26 The trend in American medical
27 and scientific research is clear. What of Canada?
28 Our investigations quickly upturned collaborating
29 Canadian research and recent change of thinking by
30 some of our senior Canadian medical researchers.

1 use leads to irreversible organic changes
2 contrary to popular belief. Under regular
3 or excessive use and abuse experience
4 now shows, he adds, that some of the symptoms
5 appear to become chronic. Some of
6 his ^{recorded} experiences suggest that there can be
7 long term adverse effects in areas such
8 as judgment, insight, recent memory, ability
9 to concentrate and emotional irritability.

10 Dr. Lundel also draws
11 attention to the papers of Dr. Conrad Schwartz
12 of Vancouver and others in which 22 different
13 personality traits have been identified,
14 which are assumed to be associated with
15 addiction to marijuana and harder drugs.
16 "Since ^{nearly} everyone has some of these traits
17 in varying degrees," Dr. Landel concludes,
18 "there is no way of predicting addiction to
19 and long term effects of marijuana among
20 users. The unpredictable nature of the
21 drug is one of its most serious dangers."
22 He further reports ^{following} the harmful effects
23 following marijuana use: 1. organic brain
24 syndrome, 2. irreversible brain damage, 3. perception
25 distortion, 4. some benders, 5. reversal
26 of social values, 6. disinterest in food,
27 7. lack of judgment, 8. memory loss, 9. lack
28 of motivation, 10. irritability and increases
29 in home and school problems, 11. potential I.Q.
30 decreases, 12. one study showed 25% of marijuana

1 users went on to harder drugs, 13. another
2 study showed 16 of 20 narcotic users started
3 on marijuana.

4 I will give more about
5 Dr. Iundel's conclusion further on in this
6 brief. Dr. Conrad Schwartz, consulting
7 psychiatrist of the University Health Service
8 and Clinical Assistant Professor, Department of
9 Psychiatry, of the University of British
10 Columbia, who has been closely involved in drug
11 studies has told us this week
12 that he has also moved in the past year or two
13 from a qualified position to one of unqualified
14 opposition to the widespread use of marijuana
15 as a result of his own and other studies. In his
16 report on general research findings about
17 marijuana use given to the Western regional
18 meeting of the Canadian Psychiatric Association
19 in Vancouver, January 23rd, 1969, he adds the
20 following items to the ones already mentioned
21 in the above material: "There are wide variations
22 in the human response to these substances of
23 hashish and marijuana and variations may also
24 occur in the same individual using the same
25 substance at different times. And further,
26 fluctuations in mood and behaviour occur and
27 a state of toxic psychosis may result
28 which is not necessarily related to high
29 dosage."

30 Dr. Schwartz goes on,

"depending on the complex interaction of a number of variables of which the drug is, one, hashish, and marijuana to a lesser degree, can be associated with actue psychological distress requiring medical attention, intoxicated behaviour dangerous to the individual himself or to others, drug dependency, personality deterioration and chronic physical ill health."

And finally, "regular users of both marijuana and hashish tend to show basic defects in personality." I may add that studies by Dr. C. Miras of Athens, Greece, after twenty years indicates that two marijuana cigarettes in a day for two years will cause the previously mentioned adverse effects, but much more study is needed in this aspect according to other men in the field. In a Canadian Medical Association Journal of March 2nd, 1968, Dr. J. R. Unwin, of Montreal, well known for his recent public presentations on drugs, at eighteen universities and other conferences, commends a 1967 paper by Dr. Schwartz as one of the few balanced and clinical evaluations of the present position of marijuana and quotes Dr. Schwartz as follows: "The problem with marijuana is that the law is not at present backed up by objective validation on the alleged dangers of this drug." However, Dr. Schwartz reported to us two days ago that his and other research since the writing of the 1967 paper, has convinced him that

1 objective validation of the damaging effects
2 of this drug is now available to back up the law
3 and has given us permission to quote him in this
4 assertion and to add that he is now strictly
5 opposed to any legalization of marijuana.

6 Dr. Landel has authorized
7 us to say on his behalf that he agrees
8 completely with the recent statement made
9 in Montreal by Dr. Unwin that since the
10 adolescent is often attempting to cope with
11 interpersonal and intrapersonal social, academic
12 and vocational problems and in the face of
13 group pressure, to use drugs is the "in" thing
14 to do, further exposing of adolescents to
15 these drugs could be hazardous. Dr. Landel
16 calls for much more adequate follow up
17 research for confirmation of these various
18 findings and states firmly that Canada would
19 be on dangerous ground if there was indiscriminate
20 legalizing of these substances. "Are we
21 falling into the trap similar to that of
22 thalidomide use by rushing ^{into} legislation," he asks.
23 While suggesting that marijuana be
24 differentiated from the more dangerous groups,
25 Dr. Yolles, who I quoted earlier, also says
26 in his recent statement, "I am certainly
27 not advocating the removal of all restrictions
28 on marijuana". Dr. Unwin, at a drug
29 conference in Charlottetown, February, 1969,
30 stated, "it is not likely that we could support

1 attempts to legalize the substance until much
2 more accurate information is available about
3 the long term effects of moderate, casual use
4 and heavy sustained use." Earlier in the talk,
5 he has said, "it is nonsense to talk of marijuana
6 as being harmless." Dr. Brill of New York
7 gave us permission this week to be quoted
8 that he is absolutely opposed to legalization and
9 that to add another drug such as marijuana,
10 to alcohol, which is openly available, would
11 be the height of folly while we still have
12 time to prevent it from reaching epidemic
13 proportions.

14 Dr. Griffith Edwards of
15 the Addiction Research Unit, Institute of
16 Psychiatry at the Maudsley Hospital in England,
17 writes in the British Medical Journal, "The
18 Practitioner", the choice is not between
19 alcohol and marijuana as socially accepted
20 drugs, but between alcohol^{alone} as opposed to alcohol plus
21 marijuana. The difficulties which
22 alcohol^{is} still presenting to most countries
23 of the world would perhaps suggest a
24 certain rashness in introducing
25 permissiveness towards the social use
26 of a second drug. Significantly, James
27 Goddard, former head of the^{United States} Food and Drug
28 Administration^{who} was widely quoted eighteen
29 months ago, when he said he would prefer
30 his daughter to smoke marijuana than to take

1 a cocktail, reversed his former lenient
2 position for the drug in a presentation
3 on Tuesday of this week,^{before}the United States
4 House Committee Inquiry on drugs in Washington
5 and I quote: "As a result of more recent
6 information, he stated that he recognizes that he
7 was in error in making that earlier statement
8 and now is completely opposed to the
9 legalization of marijuana. I also note
10 that in the past two weeks the Government of
11 Great Britain has resisted^{great}pressures and
12 has finally refused to legalize marijuana.
13 What small play this received in the Canadian
14 press when the subject is such a hot issue
15 in this country. Why? We heard of it
16 from an English newspaper. In view of the now
17 clearly established social and personal
18 and harmful effects of continued marijuana
19 usage, in view of the fact that various nations
20 of Asia and the Middle East, who have had
21 widespread open use of the drug, now prevent
22 its continued use due to the widespread harm
23 caused and noted in the International United Nations
24 agreement^{of}which Canada is a signatory to
25 stop trafficking in marijuana and being aware
26 also that there is a great increase elsewhere
27 in Canada, in the stronger hashish variety
28 which has 40% active ingredient against 8% in
29 marijuana and highly important in facing the
30 evidence that drugs are in use by younger and

1 younger adolescents, even children, we
2 therefore strongly condemn any move by this
3 Commission to recommend or any move
4 by the Federal Ministers of ^{Health or} Justice, to
5 liberalize or/ the use of marijuana at this time
6 as a betrayal of the trust which the people of
7 Canada have placed in you and the betrayal
8 of social and medical principles under which
9 other drugs such as cynamates are abruptly
10 removed from the market when only preliminary
11 research has indicated possible human damage
12 with their use.

13 Indications from current
14 research of marijuana compel any objective
15 observer to insist that far more research is
16 needed before any liberalization could possibly
17 be considered. Marijuana and other drugs
18 are not yet a serious problem, on Prince Edward
19 Island, nor is there widespread use. For
20 Ottawa to force upon us open use of this
21 drug by legalization where our children would
22 be exposed daily to its use, is a totally
23 unacceptable position to this government.

24 I must remind the
25 Commission again that we have not sought to
26 present the pros and cons ^{the effect of} of marijuana, but
27 instead to establish the strength of evidence
28 that it is a harmful drug. This is sufficient
29 to prevent any move to legalization. We
30 also agree with Dr. Volles, Dr.

1 Lundel, and others that some move can be made
2 to modify the legislation so that occasional or
3 youthful experimenters will not be placed
4 under the same heavy criminal penalty
5 provisions as the active pushers but --
6 and I wish to emphasise this point -- even
7 here, youth must understand that in any
8 provisions of the law that it is still illegal
9 and a no nonsense matter. Our recommendations
10 call for hitting hard at the active pushers
11 of the drug, and this is in line with the
12 thinking of Drs. Lundel, Schwartz, Brill and
13 other eminent experts as well as the
14 recommendations of our governments'
15 professional people.

16 There was no time, unfortunately,
17 to work out/detailed recommendation as to how
18 such changes may be made. No legal methods
19 alone will effectively deal with the problem, although

20 the evidence of our study clearly demonstrates
21 the need for legal restriction and police
22 protection if society is to function well.

23 Underlying causes must also be cleared up.

24 All agree that youth require much more factual
25 information about the dangers of drug use,
26 although there is some danger of causing an
27 attraction to drugs if it is presented at

28 too tender an age. A full all out educational
29 program on drug dangers is immediately needed.

30 I recommend strongly that the

1 problem be placed before a youth group and that
2 they be encouraged to take responsibility
3 themselves of handling this dangerous problem.
4 Given the responsibility, youth has shown
5 that it is amazingly responsive. It is to be
6 hoped that your forthcoming preliminary
7 white paper will not prove to be a whitewash
8 of the glaring evidence now available about the
9 harmful sides of marijuana. I repeat and
10 insist that you will betray your trust if
11 you do not present the negative evidence
12 as strongly as Drs. Yolles, Lundel, Schwartz,
13 Brill, and others have done.

14 In all of this, we have
15 not forgotten LSD and other drugs. We note
16 that Dr. Yolles in his statement two weeks
17 ago said, "It appears that stronger and more
18 dangerous drugs tend to displace weaker drugs
19 during this period of excessive preoccupation
20 with mind altering chemicals. One further
21 identifiable ominous trend is the indulgence
22 in drugs of abuse by younger and younger
23 aged groups", and adds, referring to LSD,
24 "the situation is not so encouraging in junior
25 and senior high schools, however, where
26 experimentation with LSD by youngsters in this
27 group may be on the increase." And continuing,
28 "It is necessary, therefore, to develop effective
29 process to curtail their abuse today." We
30 comend to you his full report. Respect for all

1 drugs should be taught through every avenue
2 available to individuals of all ages.

3 "People", he continues, "must be motivated to find
4 for themselves that the world has not changed
5 for the better when individuals retreat from
6 trouble via a magical pill. A drug may
7 remove the person from the world for a time
8 but the world remains unchanged, including the
9 dimensions of the drug dependence problem.

10 In our homes, in our
11 schools, in our churches, in all of our
12 associations let us move forward with our
13 young people, spending more time with them,
14 doing interesting things together, finding that
15 the world is full of exciting challenges and
16 opportunities and that with the appropriate
17 attitude we can and will find a better
18 world for their future and learn to make the
19 normal and ordinary but necessary things of life
20 more interesting and enjoyable."

21 Let me agree with Professor
22 (Kenneth Dennison) of Yale who has studied and
23 understand alienated youth perhaps better than
24 anyone else:

25 "In the long run those of
26 us who are critical of student drug abuse must
27 demonstrate to our students that there are
28 better and more lasting ways to experience the
29 fullness, the depth, the variety and the
30 richness of life than that of ingesting

1 psychoactive drugs. And we could perhaps
2 in our own lives and in our own examples,
3 suggest that moral courage, a critical
4 awareness of the defects in our society, a
5 capacity for intense experience and the ability
6 to relate genuinely to people, are not the
7 exclusive possession of drug users. This is the
8 ultimate challenge."

9 And in conclusion, Mr.
10 Chairman, members of the Commission, I would
11 like to quote Mrs. Joseph Kennedy, the mother
12 of the most modern, dynamic family, of sons
13 and daughters of the North American continent
14 if not of the world, and her words should not
15 be taken lightly, when she says in a recent
16 publication:

17 "I think it is stupid for
18 the young to experiment
19 with drugs. Youthful
20 people need their best brains
21 and their most acute
22 reaction for their fight
23 for a better world and to
24 damage their mental capacities
25 for the sake of a few thrills
26 is ridiculous. Along with
27 their dynamism the young
28 must guard against childish
29 collapse or destructive rage
30 in the face of disappointment.

1 This kind of resilience
2 of spirit cannot come from
3 drugs. It still can come
4 in a great measure from the
5 inspiration and philosophy
6 instilled in the early
7 years by parents. If the
8 children have been properly
9 motivated they will have a
10 strong willpower. And if they
11 know something may be dangerous
12 to their health they will have
13 been so disciplined in their
14 youth that they will be able
15 to resist new temptations.
16 They will take pride and
17 have confidence in their own
18 independent judgments and they
19 will have the zest enough
20 to climb mountains or
21 seek the stars without the
22 help of questionable stimulants.
23 There is no place for boredom
24 in a mind that is constantly
25 seek new horizons."

26 Mr. Chairman, members of the
27 Commission, that is my brief, and I may say again,
28 that this is the stand that is taken by the
29 government of Prince Edward Island.

30 THE CHAIRMAN: Thank you,

1 Mr. Attorney.

2 Any questions or comments?

3 I was wondering, Mr. Attorney,
4 if you could give us your views on the
5 enforcement of the present law, whether you
6 believe the present law against possession to be an
7 effectively enforceable law, whether you have
8 any observations to make on its administration
9 on the sentencing policy and its effect on those
10 to whom it has been applied. You have made
11 allusion to the possibility of change in the
12 present law, and I think as Attorney General
13 we would be very indebted to you if we could
14 have the benefit of your experience as an
15 officer of the Crown on those questions.

16 ATTORNEY GENERAL BLANCHARD:

17 Mr. Chairman, I feel very strongly
18 that
/there has to be a change in the way that we
19 have in the past branded young people with
20 criminal records.

21 The rashness of youth, the
22 energy displayed by young people, it is quite
23 possible for the people without maturity of
24 judgment to get into minor trouble or very
25 serious trouble. To brand a young person
26 in his teens, possibly early twenties with a
27 criminal record that hangs as a milstone
28 around his neck for the rest of his life, I
29 think doesn't reflect the justice that we really
30 look for in this country.

With respect to the enforcement of the law against the young person who happens to get caught with the possession of marijuana or any other drug, I feel that society must not condemn that young person who makes that first initial experiment. I feel that there has to be some leniency that he shouldn't be branded with a criminal record. But there is a double-barrelled idea here, that at the same time the Courts must impress upon that young man that he has engaged in an illegal activity. And as I stated in the brief, that it is a no nonsense area that he finds himself. I feel that any move in this direction where it would be left entirely up to the discretion of the Courts to deal with that young offender as justly as possible, but at the same time emphasize and get the point over that it is an illegal matter and that he has had his experiment and that it shouldn't happen again. I don't know whether my rambling here has conveyed my thinking.

THE CHAIRMAN: Mr. Attorney,

if I might just pursue that a little further.

As I understand it, that you would favour the retention of the criminal law stigma against possession for use; that is to say, you would favour the retention of the criminal law prohibition against possession for use?

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ATTORNEY GENERAL BLANCHARD:

Yes, but I think we have to move away with the idea that this young person of sixteen or seventeen years of age is a criminal just because he ^{happens} / to be brought up before a Court and is found to be guilty of this offence.

Yes, I agree with you, but I don't want it understood that I want this young fellow to have a criminal record.

THE CHAIRMAN: Right.

But you want the act to remain illegal, the act of possession?

ATTORNEY GENERAL BLANCHARD: Yes.

THE CHAIRMAN: For simple possession for use, but you do not want a criminal stigma?

ATTORNEY GENERAL BLANCHARD: Yes.

THE CHAIRMAN: Have you given any thought to the constitutional issues here, Mr. Attorney.

ATTORNEY-GENERAL BLANCHARD:

No, I haven't, and as I mentioned in my brief, the time did not permit me to make any recommendations with respect to how these matters should be handled.

THE CHAIRMAN: Would you be prepared -- would your government be prepared to assume if this ^{were} / Constitutionally feasible to assume the responsibility for the prohibition against possession for use?

1 ATTORNEY GENERAL BLANCHARD:

2 Responsibility for which?

3 THE CHAIRMAN: Assume the

4 responsibility for enacting of prohibition against
possession

5 /for use. I am asking whether the federal

6 government has any^{other} way of prohibiting except in

7 a criminal way here.

8 ATTORNEY GENERAL BLANCHARD:

9 Frankly, right at the

10 moment, I don't think the law prohibiting the

11 use of marijuana or any other drug should be

12 changed. What I am talking about are what

13 the penalties --

14 THE CHAIRMAN: You are

15 speaking of the penalties?

16 ATTORNEY GENERAL BLANCHARD:

17 That's right.

18 THE CHAIRMAN: But you are

19 speaking of removing the criminal law stigma,

20 aren't you? How can this be other than

21 criminal law if it is to remain as a prohibition?

22 ATTORNEY GENERAL BLANCHARD:

23 If it can't be worked, we

24 will have to look at something else.

25 THE CHAIRMAN: You haven't

26 considered that yet?

27 ATTORNEY GENERAL BLANCHARD:

28 No, we haven't considered

29 that yet.

30 THE CHAIRMAN: What, Mr.

1 Attorney, is your impression of the sentencing
2 policy in Canada so far as the head of the
3 administration of justice in the province, what
4 is your feeling about the pattern of sentencing
5 policy with respect to these drug offences,
6 and in particular, these possession offences?

7 ATTORNEY-GENERAL BLANCHARD:

8 Well, my opinion on this
9 is, you hit hard at the pusher.

10 THE CHAIRMAN: But you are
11 suggesting that there should be an exercise
12 of a certain kind of discretion by the
13 judiciary with respect to the offence of
14 possession and particularly with respect to
15 the first offender.

16 What is your view of the
17 exercise of discretion that is being conducted
18 so far by the judiciary in this field?

19 ATTORNEY GENERAL BLANCHARD:

20 Well, we had up until about
21 three years ago -- I don't think we had a court
22 case at all on this matter in this province.
23 We have had a few since.

24 I feel that from our
25 experience in this area, it is not very great,
26 but I think the courts have handled the matter
27 adequately. They have given great leniency
28 in the matter of first offenders in cases of
29 possession in the nature of suspended
30 sentences. However, I still maintain that

1 for the pusher this is where your hard, severe
2 sentences help. Because this fellow is the
3 cancer of society.

4 THE CHAIRMAN: Having regard
5 to the kind of controversy that you indicated
6 in your view of medical evidence, if your concern
7 for leniency to the first offender charged with
8 possession were in fact to be considered
9 in the majority of you, it expresses a majority
10 feeling in this country, how do you communicate
11 this kind of policy, or how do we assure this
12 kind of policy is reflected in the exercise of
13 judicial discretion?

14 ATTORNEY GENERAL BLANCHARD:

15 Well, this is rather
16 difficult, very difficult indeed, I would say.
17 You know, whether you would set up courses for
18 judges, I don't know. I would be a bit hesitant
19 to criticise any of the judges, but I think
20 perhaps that probably the suggestion is not too
21 far out in left field at all. Because I feel
22 that we haven't had enough exposure public-wise,
23 and particularly professionalwise, that is,
24 in the court structure to the information on
25 the use of drugs.

26 THE CHAIRMAN: One of the
27 things we heard across the country is statements
28 of the alleged discrimination in the application
29 of the law. It has been said to us that
30 since this drug use is spreading so much in

1 our society it is spreading into classes
2 which have not formerly had much of a contact
3 with the criminal law, that there is a strong
4 suspicion developing in the country that this
5 law is not only -- is not capable of non-discriminate
6 application given all the social implications
7 involved. What is your own feeling about that?

8 Now, that is a statement
9 that has been made to us, but it has been
10 made to us very often.

11 ATTORNEY GENERAL BLANCHARD:

12 You mean the variation of the
13 sentences?

14 THE CHAIRMAN: Well, because
15 of the various groups involved that the law is
16 going to be inevitably discriminatory in its
17 application, certain people are going to be
18 selected for investigation and others, for other
19 reasons, are not going to be. That, in other
20 words, what is being said to us, that the way
21 the situation exists today, it is impossible to
22 enforce this law in a non-discriminatory way,
23 in other than a very selective way, if we are
24 not to have a much greater social program on our hands in
25 relation to the administration of justice.
26 This has been said across the country.

27 ATTORNEY GENERAL BLANCHARD:

28 Well, we have this complaint
29 right here in Prince Edward Island, where you get
30 a variation. But perhaps if this is a

1 prime criticism perhaps we should be looking to
2 see if we can't get a more uniform application
3 of the penalty provision. Is this what you
4 are driving at, Mr. Chairman?

5 THE CHAIRMAN: Yes, I am
6 asking you in your professional judgment whether
7 this law in the present social conditions is
8 really one capable of non-discriminatory
9 enforcement, but a matter of realistic
10 administration of justice.

11 ATTORNEY GENERAL BLANCHARD:
12 You know you can apply
13 that to any other area.

14 THE CHAIRMAN: I think that
15 the way the statement is put to us, it is now
16 affecting too many people who had hitherto had
17 no contact with the criminal law, who would not
18 be singled out and the pressures that are being
19 caused by this situation are making an undiscrimi-
20 natory application extremely difficult and it is
21 putting policemen and judges in extremely difficult
22 situations, and I am simply repeating statements
23 that have been made to us.

24 ATTORNEY GENERAL BLANCHARD:
25 Yes, I realize that, and I
26 am aware of these situations as a matter of fact.

27 THE CHAIRMAN: I was wondering
28 in your professional judgment whether you feel
29 there is possibly force in these statements?
30

ATTORNEY GENERAL BLANCHARD:

Well, I know of situations where they find there are great variations, but perhaps we should be looking into this area not only with respect to drugs, but in almost any area where prosecutions come into play because in the past we did not have this instant communication that we have. Now we hear of these various things happening, in the different parts of the country, and the world, but in former days we were limited pretty well to our own little neighbourhood. I think we have got to start looking beyond these boundaries to see if perhaps we can't get some sort of a national consensus on this matter of sentences and on the way of handling them.

THE CHAIRMAN: Professor Bertrand?

PROFESSOR BERTRAND: Mr. Blanchard, I don't think it was in one of your quotations of Mr. Yolles, but you mentioned that the marijuana user could get so involved in taking the drug that his drives would be impaired. Am I right in assuming that this applies of course only to the actual situation, meaning that any user of marijuana has to get it through illegal channels and of course to search for it and sometimes pay a high price for it, and so meaning if a more liberal or more accessible drug would be there

1 we could^{not}/assume that someone^{who}/would like to
2 get marijuana would have to be so involved in
3 getting it that his drives would be impaired?

4 ATTORNEY GENERAL BLANCHARD:

5 Well, all I can answer
6 to that, is that this is Dr. Brill's statement.

7 PROFESSOR BERTRAND: It is
8 Brill, I see, I thought it was yours.

9 ATTORNEY-GENERAL BLANCHARD:

10 No, I am sorry, this is Dr.
11 Brill's statement and he has convinced me that this
12 is so. I think your question should be posed
13 to Dr. Brill.

14 PROFESSOR BERTRAND: Yes.
15 Then you said that you did not want to weigh
16 the pros and cons and I think that in all these
17 hearings I have often heard too many propositions
18 contrary to the legalization or liberalization
19 of the drug, but you also said that you
20 didn't see or the authors that you quoted,
21 did not see any beneficial effect whatsoever,
22 in the use of marijuana. Am I right in that?

23 ATTORNEY-GENERAL BLANCHARD:

24 Yes. Again, I quote
25 these various authorities as having said that.

26 PROFESSOR BERTRAND: Yes,
27 I know, but may I ask you a personal question
28 then? Would you feel that relaxation
29 is a beneficial effect?

30 ATTORNEY GENERAL BLANCHARD:

1 No, absolutely not, not until we know further
2 about the drug. The latest evidence indicates
3 that it is a harmful drug.

4 THE CHAIRMAN: I think that
5 Professor Bertrand meant, I understood; how would
6 you regard relaxation as an effect by itself
7 without looking at other effects, just as an
8 effect?

9 ATTORNEY GENERAL BLANCHARD:
10 How can you regard it
11 without relating it to something else? You know
12 you can't isolate just relaxation without
13 relating it to -- you know, I could be a
14 relaxed bank robber.

15 PROFESSOR BERTRAND: You can
16 also be a relaxed person taking a holiday.

17 ATTORNEY GENERAL BLANCHARD:
18 But you have to relate it to
19 something. I don't think you can say there is
20 relaxation, what effect is that going to have?
21 What effect on what?

22 THE CHAIRMAN: This is
23 very important, Mr. Attorney, -- if I may --
24 this is a very important issue that we sort of
25 have a common assumption as to our task as
26 you have spoken of our responsibility.
27 I understood your approach to the analysis of the
28 facts, that is the statement of the facts, to
29 be essentially what our approach is, namely to
30

1 try and identify the effects and then there is the
2 process of evaluation, obviously, to which you have
3 been just referring. But I take it from what you
4 have just said that you do not pass over the stage
5 of identifying individual effects because you
6 come to a general judgment or assess the thing
7 as a whole, you don't pass immediately to
8 that and say, "I don't want to consider those
9 effects because my judgment of the whole is such
10 that those other effects must be excluded."

11 We see it as a two stage process and we must
12 first try to find the alleged facts respecting
13 the various defects and there is no doubt
14 a judgment to be made on each of the effects
15 and the totality of the effects.

16 I just want to make sure
17 that we are thinking alike as to what we mean
18 by fact here.

19 ATTORNEY GENERAL BLANCHARD:

20 The authorities that I have
21 quoted this morning state that marijuana is
22 a harmful substance, and my contention is that
23 there are no pros and cons to it. My contention
24 is that while that drug is a harmful substance,
25 it must be controlled in society. There may
26 be counter-arguments but this is the latest
27 research that I have quoted.

28 THE CHAIRMAN: I understand
29 that, but I think the question from Miss Bertrand
30

1 -- that we are pursuing here -- relates mainly
2 to education. You said that we must have
3 full and reliable information -- youth requires
4 more information. In any event, it was as
5 I recall full and reliable information both for
6 youth and for parents, if I am not mistaken.

7 Now, I think the thing that
8 we are pursuing here is that in giving this
9 information, providing this information,
10 are we -- I am speaking as society now --
11 are we to give such information as we think
12 may be reliable concerning positive effects?

13 Now, let us assume, for the
14 sake or argument, that it can be ascertained
15 reliably that it does have the effect of a
16 relaxant -- are we to mention that effect
17 with such valuation of it by itself as we
18 see fit; are we to ignore that for fear
19 that that is going to convey on balance,
20 the impression that we think should be
21 conveyed on balance about the drug?

22 Now, you just conveyed your
23 impression on balance about the drug, as I
24 understand, based on the statements of various
25 authorities who themselves have some doubt about
26 the assessment of the drug. But in speaking of
27 information as opposed to exhortation,
28 let us say, speaking of information, are we
29 to tell, objectively and as fully as we can,
30 all the facts, reliable facts pertaining to the

1 drug, although some of them may be positive
2 and some of them may have an effect of
3 attenuating the overall evaluation which you
4 may think as a matter of social policy is
5 desirable? This, I believe, is very important.

6 ATTORNEY GENERAL BLANCHARD:

7 Yes, I feel that all the
8 information has to be given, all the information,
9 but it all depends on the presentation of that
10 information. If we are going to have TV
11 programs, let's say that are going to show
12 to impressionable young people the various
13 methods that you use to inject certain chemicals
14 into your body, which are possibly harmful,
15 I don't think I would go along with that.
16 But yes, the cold, objective, hard facts,
17 on both sides definitely, because all
18 information has to be available. But it must
19 be reliable information and it must be good
20 information.

21 THE CHAIRMAN: Mr. Attorney,
22 have you given any thought as to how we can
23 develop a process by which the information,
24 the needed information can have the essential
25 validity, can in fact be accepted by a sufficient
26 number of people, as reliable?

27 ATTORNEY GENERAL BLANCHARD:

28 I agree with you there.
29 I say this, that you can't go to a person on the
30 street and expect him to give you a valid opinion

1 from his own knowledge on the
2 pros or cons or both sides of the argument
3 on drugs, because most of us depend on the
4 expertise in the case of drugs. I don't
5 know the first thing about drugs. I depend
6 on the knowledgeability and on the objectivity
7 of those who are in the drug research business
8 to give me their opinions. Otherwise we
9 couldn't operate.

10 THE CHAIRMAN: Do you see
11 any role, Mr. Attorney, for^a/federally established
12 agency of some kind, attempting to develop
13 this information in a way that would command
14 acceptance scientifically and making this
15 information available to the rest of the
16 country and to be used as provincial agencies
17 of education see fit? Would you approve
18 of that kind of --

19 ATTORNEY-GENERAL BLANCHARD:
20 I would highly recommend
21 this sort of thing. I feel that people in
22 general just have not got enough information
23 on that.

24 MR. CAMPBELL: There are
25 three matters sir, I would like to raise with
26 you.

27 When you were discussing
28 the treatment of the first offender, you spoke
29 particularly of people in their teen and early
30 twenty years. Would you extend the

1 application of more lenient treatment to
2 people in older age groups? It has been put
3 to us that while there is not as widespread
4 experimentation taking place with marijuana, there
5 is experimentation by adults; or was your suggestion
6 confined exclusively to young people?

7 ATTORNEY GENERAL BLANCHARD:

8 I think I would go along with
9 the first offender, in any case.

10 MR. CAMPBELL: When you spoke
11 of the first offender you prefaced your remarks
12 by suggesting it was necessary for us to think
13 very seriously about the consequences of a
14 criminal record for young people who might have
15 behaved, as I think you put it, irrationally,
16 or without calm consideration. I have interpreted
17 your remarks as the statement for the general
18 principle, not merely applying to drugs, but a
19 general concern for the criminal record implication
20 of young people which you are then implying speci-
21 fically to the case of drugs, am I correct?

22 ATTORNEY GENERAL BLANCHARD:

23 That is correct.

24 MR. CAMPBELL: All right.

25 The third matter that I was concerned with:
26 you made your remarks particularly with reference
27 to the first offender, the young first offender.
28 Is it your opinion that the criminal record
29 possibility and the possibility of relatively
30 severe sanctions should be maintained for

1 the rescindment, irrespective of age.

2 In other words, if you were given, hypothetically,
3 a teenager who was picked up for the second
4 time for using marijuana, what would your
5 reaction be in this instance?

6 ATTORNEY GENERAL BLANCHARD: Well,
7 for instance in the Criminal Code, the courts now
8 have the option that the special merits of
9 each situation considered and let's say a second
10 suspended sentence can be imposed, even though
11 the crime of the offence has been committed
12 while the first offence -- while the first
13 suspension, suspended sentence is in effect.
14 And I think that our courts here should be
15 given discretion as well. Because I think
16 they must take into consideration the
17 circumstances surrounding each individual as
18 to whether that person should be then sentenced
19 or should not be and perhaps further leniency be
20 shown to them.

21 MR. CAMPBELL: In other
22 words, you want a continuing discretionary
23 power in the court?

24 ATTORNEY GENERAL BLANCHARD: I
25 would say so, yes. Because I think you always
26 have to remember that if you can salvage one
27 of these people, the discretion should be there
28 to do it.

29 MR. STEIN: Would you care
30 to make -- you mentioned the analogy to alcohol

1 may be, in your estimation, specious at times.
2 Until recently the user of alcohol was dealt with
3 by criminal courts and very often is still done
4 so in Canada. Do you have any views of the
5 appropriateness of dealing with the user of alcohol
6 in a criminal fashion, the person who is
7 using alcohol to excess perhaps?

8 ATTORNEY GENERAL BLANCHARD: Are
9 you talking about the person who is found drunk,
10 or are you talking about the person who has
11 personal problems involving alcohol on a
12 continuous basis?

13 MR. STEIN: Well, I am leaving
14 it open. Do you feel that there are any times
15 when it would be appropriate to use the
16 criminal process for a person who is using
17 alcohol?

18 ATTORNEY GENERAL BLANCHARD: No,
19 the problem is very complex; I don't have to
20 tell you that. But I do feel this, and I
21 look forward to the day that perhaps well --
22 let's deal with one first -- that drunkenness will
23 be no longer treated as a crime and that there
24 should be no charge levied.

25 Granted the public have to
26 be protected, but just drunkenness in itself
27 I don't think should be considered as a crime.
28 There should be no charge. Perhaps the police
29 could take the person and put him in the lock up
30 over night, and release him the next day.

1 I think Alberta and British Columbia are
2 already into this area. But on the question
3 of, let's say, the alcoholic, the person who
4 has continual problems with alcohol, that we
5 have to set up some kind of different treatment
6 that he too shouldn't be the subject of jail
7 sentences. I can't think of anything more
8 useless, putting an alcoholic in jail to spend
9 several days in a living hell.

10 MR. STEIN: Well, the
11 suggestion has been made to us the appropriate
12 role for the Criminal Law is to deal with those
13 acts or that behaviour which is demonstrated
14 beyond a reasonable doubt to be dangerous to
15 others, drinking and driving, as an illustration,
16 aggressive behaviour under the influence of
17 alcohol might be another example. What is
18 your view, and I am returning to the
19 question of marijuana, of those who have
20 suggested that the use of the drug in and of
21 itself ought not to constitute a criminal
22 offence, that the criminal offences ought to be
23 specifically related to that behaviour. Maybe
24 that behaviour is taking place during the time
25 of the consumption of the drug, but it should
26 be related to that behaviour which has
27 clearly, beyond a reasonable doubt, demonstrated
28 it to be interfering with others, whereas the
29 pure and simple use by an individual ought not
30 to be considered a crime.

This is a contention that has been made to us and I am wondering, if, in your presentation, regarding the desire not to change the law and use in the light of what you just said about alcohol, whether you have anything further -- any further observations on that kind of a statement?

ATTORNEY GENERAL BLANCHARD: No,
I haven't. Are you suggesting that there is an equation
between alcohol and marijuana? I hold that
there isn't.

THE CHAIRMAN: No, I think, Mr. Attorney, it is the question of whether they have not got this in common, that they are alleged to involve harm to the individual who uses them. They are both alleged to involve harm to others when certain acts are performed while under their influence. But the criminal law, and this is the statement, that the criminal law should not be applied to the use of either of them except to the extent that such use is clearly shown to involve conduct which causes harm to others, not just the user, that is the hypothesis, that you are invited to consider. That the criminal law should not be applied to the case where the harm, the alleged harm that is caused is only to the user,^{the} individual. That is the hypothesis we are invited to consider as to the function and purpose of the criminal law today. My colleague,

1 Miss Bertrand, observes that the Ouimet Commission
2 has said something which is said to support this
3 general thought.

4 ATTORNEY GENERAL BLANCHARD: Well,
5 as they say, although I haven't given it that
6 much thought, but I am not inclined to agree
7 entirely that the law of the land only applies
8 to acts between a man and his neighbour.
9 I think that in certain circumstances that
10 you have to protect the man against himself.
11 It is just the same thing as, you know, we
12 do this all the time, we, the
13 public, we have inspections of everything from
14 needles to haystacks.

15 THE CHAIRMAN: Yes. In
16 other words, Mr. Attorney, you would say that
17 there is a responsibility of government to protect
18 individuals from harm, and from harming themselves?
19 I would assume for example one would think of the
20 restrictions on the availability of harmful
21 substances. But does it go so far as to
22 protect him by punishing him for the use of a
23 substance? Do you think that that responsibility
24 extends to seeing that you punish him,
25 you protect him from harming himself or
26 deter him from harming himself by punishing him
27 when / he does so?

28 ATTORNEY GENERAL BLANCHARD: He
29 is just not harming himself, he is harming
30 society.

1 THE CHAIRMAN: We come
2 back to the harm of the third person, as the
3 justification for that.

4 ATTORNEY GENERAL BLANCHARD: Grant
5 you this is where it comes in. Otherwise, the state then
6 has to provide accommodation for this
7 fellow in a mental hospital or has to provide
8 for his family through the welfare courts.

9 So when you say he can only
10 harm himself I don't think that you can say
11 that.

12 THE CHAIRMAN: I am only
13 putting up a hypothesis now, Mr. Attorney.

14 ATTORNEY GENERAL BLANCHARD:
15 Assuming that each individual citizen is
16 a part of the whole and the whole can be
17 affected when a number of individual citizens
18 can find themselves into a situation such
19 as a drug user. He may consider his
20 own private domain, but where it is harmful I
21 think that the state must come in and say it
22 is harmful and it must control that.

23 DR. LEHMANN: Mr. Attorney,
24 along these lines, if the state must interfere
25 with such harmful devices, one might say, as
26 the recreational drug use would be such as
27 cannabis, for instance, what I would like to
28 clarify is, in your opinion, the state's
29 responsibility restricted to recreational drugs
30 as a recreational device or also to other

1 recreational devices, for instance, the Ski-doo
2 which is still pretty new. A lot of deaths
3 have occurred and a lot of pollution, a lot of
4 nuisance to other people and danger to other
5 people, too. Also a lot of recreational
6 value in it.

7
8 Now does the state have a
9 responsibility to interfere specifically with
10 harmful substances only or with any kind of harmful
11 recreational activity or device?

12 ATTORNEY GENERAL BLANCHARD: I
13 think it has to interfere.

14 DR. LEHMANN: Well, Ski-doo
15 are quite legal.

16 ATTORNEY GENERAL BLANCHARD:
17 Ski-doo are quite legal, but they are not legal
18 in this province, for instance, to travel on
19 a highway, and there are regulations in this
20 province, regulating the use of Ski-doo and
21 they are very actively enforced.

22 DR. LEHMANN: Well, one
23 could think then of devices or regulations
24 for the use of marijuana not while one is
25 driving for instance, frequency and so on.

26 ATTORNEY GENERAL BLANCHARD: Well,
27 let's put it this way, sir, we are talking
28 specifically about drugs, but if there is a food
29 that has been proved to be harmful, regardless
30 of whether it is a drug or anything else,
do you not think that the state has the

1 authority to interfere or has the duty and
2 the obligation to interfere from that poison food we eat.

3 PROFESSOR BERTRAND: Inter-
4 fere, but we all have in our homes poisonous
5 substances like iodine, and we do not go to jail
6 for that.

7 ATTORNEY GENERAL BLANCHARD: That
8 is quite true, yes.

9 DR. LEHMANN: There is no
10 specific reason, you feel, that the state
11 should interfere with harmful substances
12 primarily, rather than other harmful devices?

13 ATTORNEY GENERAL BLANCHARD: I
14 am sorry, would you mind repeating your question?
15 I was thinking of the iodine incident.

16 DR. LEHMANN: I am trying to
17 establish whether, if the state is to interfere
18 with harmful recreational devices, which have a
19 potential harm, carry potential harm, whether
20 such devices should be specifically chemical
21 substances, drugs; in other words, whether one
22 is focusing more, first of all, on drugs,
23 rather than on other potential, harmful
24 recreations.

25 ATTORNEY GENERAL BLANCHARD: I
26 think the state has to move when the occasion
27 presents itself. I don't think it should
28 concentrate in any particular area, but
29 where the state sees that a thing has to be
30 controlled, it has to be controlled. This is

1 why governments are elected, the welfare of the
2 common good.

3 Sometimes we are away behind,
4 sometimes we are ahead.

5 THE CHAIRMAN: Gentleman
6 at the microphone?

7 THE PUBLIC: Mr. Chairman,
8 I have just a few comments to make and comments
9 which sort of ask questions and call for reactions.
10 They are not really stated as definite views,
11 because I am not a person that has very many
12 definite views, with respect to the question
13 at hand.

14 THE CHAIRMAN: Who are you
15 going to address the questions to?

16 THE PUBLIC: Well, some of
17 them to Mr. Blanchard and I would appreciate some
18 reactions from members of the Commission, if that
19 is permissible.

20 THE CHAIRMAN: Don't be too
21 hopeful because we are not here to express
22 our judgment.

23 THE PUBLIC: All right, fine .

24 THE CHAIRMAN: We will do that
25 at the proper place and time.

26 THE PUBLIC: I think that the
27 questions or the comments should be seen as coming
28 from a young person fresh out of college, that is
29 confused by the things that he sees in newspapers
30 and the reports that he hears and the talks he has

1 heard given at different conventions and
2 conferences and this kind of thing, and should be
3 seen as coming from a young person that feels
4 himself privileged to be working with other
5 young people in programs of education.

6 Also I think seeing as a
7 young person who tends to agree with the basic
8 orientation that he interprets from both what
9 Mr. Blanchard has said and what Mrs. Ross said
10 earlier. Legalization, I see, anyway, is
11 a more complex question than in many ways a
12 lay person can appreciate. The kind of
13 question that touches on availability, on
14 rehabilitation of the user or the pusher, on the
15 deterrent effect perhaps that law has on the
16 total society and on the injustice that perhaps
17 we could be doing to young people, or to any
18 person who offends the law and is placed in
19 jail, primarily as a punishment because there is
20 very little rehabilitation takes place in jails
21 or penal institutions in Prince Edward Island,
22 as I understand it.

23 I am not really sure what
24 legalization entails but I am wondering in the
25 light of what Mr. Blanchard has said, if he
26 doesn't feel that ^{we are} perhaps getting hung up on the
27 question of legalization which I don't see
28 as the central issue in the whole drug question
29 in Canada.

30 I am wondering what about

1 the Commission as well, but I don't imagine you will see
2 fit to comment. I am wondering about what you
3 said, Mr. Blanchard, in the light of the court
4 exercising power with respect to the youthful
5 offender. If you see a need ^{in P.E.I.} for a great deal
6 more professional helping agencies to be working
7 closely with courts, you know social workers
8 who are involved in the actual workings of the
9 court, psychologists who are involved in
10 the workings of the court and this kind of thing,

11 I am wondering with respect
12 to what you said about education, is maybe the
13 real problem, isn't so much that everybody
14 saying that kids need more factual information
15 -- all of us need more factual information,
16 and I probably agree with that, except I am
17 wondering if we shouldn't be stressing the
18 responsibility that we have to provide for
19 our young people some kind of meaningful
20 outlets within the society for the kinds of
21 idealism that they have. If we don't
22 have a responsibility to provide to them some
23 kind of example of what life is all about, how
24 they can exercise humanitarian values that
25 they seem to have, without searching for those
26 kinds of answers in drug experience, and as I
27 understand drug experience, that seems to be
28 what many young people are searching for.
29 It is the question that the junkie priest brought
30 up very firmly when he was here last winter,

1 that there is a need for them to stress the
2 development of the total person so that you
3 get the person that can relate to this society
4 with the knowledge of himself to the point
5 where he doesn't need to go outside of himself
6 to a pill or a bottle for this kind of thing.
7 It is interesting to note, also, that Father Egan
8 has come out very strongly against legalization
9 at a recent conference that I was privileged to
10 attend.

11 I am also wondering, Mr.
12 Blanchard, too, if there isn't a danger in the
13 kind of presentation that you have made, that
14 people would see, would paint a picture or
15 would label young people as fitting into the
16 kinds of things that you said without realizing
17 that the majority of young people don't use
18 drugs and the majority of young people aren't
19 having great deals of problems, or a great deal
20 of hang ups with drugs, because I feel very
21 strongly that we need some kind of an
22 expression of faith in ourselves and the ability
23 that our kids have to search out many of these
24 answers for themselves.

25 I was a bit disappointed when
26 you were talking about education, that
27 representing the government, you didn't see fit
28 to point to the Allied Youth Program which your
29 government very strongly supports and I say
30 that, because this afternoon I am going to a

1 conference with three hundred teenagers,
2 and just over the course of the month of February
3 I will be attending rallies of over two thousand
4 teenagers in Prince Edward Island, rallies that
5 these kids have organized themselves, as a way
6 to search out answers to many of the questions
7 that were put. And I really think that we
8 should be saying to these kids that, you know,
9 we feel you are doing wonderful things and we
10 have faith in you, and we would like you to
11 continue, this kind of thing.

12 One other comment that I have.
13 I hope that people in government and the people on
14 the Commission would recognize the terrific
15 responsibility that they have, must necessarily
16 be seen in the light of the welfare of our
17 young people and their lives in society,
18 and not so much in the light of political
19 expediency or media emotionalism.

20 I think in Prince Edward
21 Island we are particularly prone to make decisions
22 with these factors affecting us rather than with
23 real concern for the people that are involved.

24 Thank you.

25 THE CHAIRMAN: Would you
26 like to come to the microphone, please?

27 THE PUBLIC: I have a
28 few questions to address to the Attorney-General.
29 They are all the aspects of one question.
30 The dangers of alcohol use have been known to

1 society for a number of thousands of years,
2 I suspect, a short time after alcohol was
3 first invented, the first chemical process,
4 the dangers of abuse were beginning to be
5 recognized.

6 Three questions, the Province
7 of Prince Edward Island developed recently -- within the
8 last decade, moved from absolute prohibition of
9 alcohol, although I gather it was used, to
10 regulate its sale through government outlets
11 and eventually to legalization of cocktail
12 lounges.

13 One, what were the
14 penalties for alcohol possession prior to
15 prohibition being lifted, on P.E.I. and how
16 did these penalties compare with the penalties
17 for marijuana possession today?

18 Two, given the long
19 accumulated historical knowledge, medical
20 knowledge of the dangers of alcohol abuse, what
21 were the considerations on the part of the
22 legislature of Prince Edward Island in changing
23 to a system of legalization under regulation?

24 Three, ---

25 ATTORNEY GENERAL BLANCHARD:
26 Excuse me, would you repeat that again?

27 THE PUBLIC: Given the
28 long tradition of knowledge of alcohol abuse
29 over the last couple of millenium, I guess,
30 what were the considerations within the last

1 decade of the legislature of Prince Edward
2 Island when it moved from prohibition of alcohol
3 on the Island, to legalization through
4 government/^{regulated}process, and three, at the present
5 time, in rough figures, what is the ^{net}government
6 revenue of P.E.I., that is after salaries, cost
7 of the alcohol, and so on, are deducted, what
8 is the ^{net}general revenue to the government of
9 P.E.I. from the government liquor outlets and
10 compared to this, what is the amount that the
11 government is turning back in rough figures,
12 for alcohol rehabilitation, education and treatment?

13 I believe we have Dr. McBeth
14 here and perhaps he might have some data on
15 this as well. Thank you.

16 THE CHAIRMAN: Thank you.
17 Yes, would you like to come to the microphone,
18 please?

19 ATTORNEY GENERAL BLANCHARD: Mr.
20 Chairman, several of these questions are being
21 thrown at me and I would sort of forget the
22 context if I ---

23 THE CHAIRMAN: Would you
24 like to apply now then, Mr. Attorney-General?
25 The Attorney-General would like to reply to these
26 questions and we would be glad to hear you, but
27 he would like to reply before he forgets the
28 question.

29 Mr. Attorney?

30 ATTORNEY GENERAL BLANCHARD: Yes.

1 On Mr. Durocher's first ----

2 THE CHAIRMAN: Could you
3 speak closer to the mike?

4 ATTORNEY-GENERAL BLANCHARD: Yes,
5 on Mr. Durocher's first question,
6 I gather from the question that he feels that
7 perhaps the brief I presented this morning
8 probably was a little too narrow -- is Mr.
9 Durocher here? Was this the question
10 that it should have dealt perhaps with the
11 rehabilitation etcetera ----?

12 THE PUBLIC: Yes, I think
13 there is a danger that we get hung up on
14 legalization as the central issue and I
15 don't think it is the central issue.

16 ATTORNEY-GENERAL BLANCHARD: It
17 may not be, and I am ready to concede this but
18 from the office I hold, this was the interpretation
19 that I wanted to get across today and I hope
20 that there are many other presentations that
21 will be made to deal with the other aspects of
22 this whole concept.

23 On rehabilitation, I may
24 say that no policy has been formulated by the
25 government either past or present in
26 rehabilitation of persons who are using drugs,
27 except on a private basis. There is no
28 government rehabilitation program -- unless
29 you consider Riverside --
30 it is involved, most certainly.

On education, I believe you are talking about the education of perhaps information getting to students, I feel that definitely there should be a very highly organized -- I don't mean in the sense that it should be government dominated, but certainly there should be very great education in the field of drugs. And I wish to apologize if I didn't mention your group specifically in my presentation, I did mention many other organizations. We contacted quite a number of them and it would have taken as long as my brief took to enumerate the ones that we did talk to. I hope you take no offence from that, but I wish

to ask you, Mr. Durocher, when you go there, to say that the government is impressed with the work that is done by your group and we hope that it will continue and grow larger.

With respect to Mr. Silverman's questions, I can't give you the penalties that were involved under the old Prohibition Act. I think we do have a couple of individuals here who may perhaps be able to give that. My colleague, the Honourable Cecil Miller, was a prohibition officer during the prohibition era and I am sure Dr. Silverman, that he would give you the benefit of his information.

On the history of the

1 transition from prohibition, prohibition to the
2 present day, on the matter of alcohol, I am
3 just not sure whether I got your question on
4 that.

5
6 THE PUBLIC: The thing
7 that I wanted to know, to repeat, is: given the
8 fact that the dangers of alcohol abuse were
9 known, what considerations prevailed upon the
10 legislature to believe that the risk was worth
11 taking since we are engaged in a somewhat
12 analogous question now. Why did the
13 legislature feel that it was worth taking this
14 risk in the case of alcohol?

15 ATTORNEY GENERAL BLANCHARD: I
16 am sorry, I can't give you that answer either.
17 I was just a tiny little fellow at the time
18 of prohibition. However, I think they found
19 that prohibition just didn't work, and didn't
20 work anywhere. On the net government revenue
21 on liquor, as I recall it, it is approximately
22 three million dollars, and as far as turning
23 back government moneys to rehabilitation or
24 welfare or medical attention, I think that most
25 of the citizens are aware of the recent
26 program that was started by the Alcoholic Treatment
27 Foundation. There is an amount of approximately
28 a hundred and fifty thousand dollars per year
29 that has been granted to this organization
30 to carry on alcoholic rehabilitation programs.

1 I might say that our welfare roles, the
2 price that it costs the province is about
3 four million dollars. We also maintain
4 Riverside Hospital and we also pay a considerable
5 amount of money to the General Hospital.
6 Maybe this isn't directly involved with
7 alcohol treatment, but I am sure-and it can be
8 separated-but I am sure that three million
9 dollars may appear as a net revenue to
10 the province, that the province in many ways,
11 through expenditures, assists in the rehabilitation
12 or at least attempts to treat these persons
13 involved with alcohol, to keep their body and
14 souls together.

15 THE CHAIRMAN: There is a
16 gentleman that wanted to speak?

17 THE PUBLIC: I wanted to
18 state first of all that I agree with Mr.
19 Blanchard's description and danger of the use
20 of marijuana. I am a retired U.S. Customs Officer
21 with more than twenty-two years experience in
22 the apprehension and arrest of users of drugs
23 and smugglers of drugs and I have never in all
24 my experience had any trouble except with users
25 of marijuana who are one of the most vicious
26 types of drug users.

27 And I can relate many
28 experiences where various crew members have
29 came on ships in irons because they had killed
30 a fellow crew member under the influence of

1 marijuana. Now, if they want to legalize
2 marijuana they might as well legalize murder
3 because you put a marijuana smoker behind the
4 wheel of a car, he has no sense of what he is
5 doing, whatsoever. He may be going fifty
6 miles an hour and he is actually going ninety.
7 He has no sense of judgment, speed or distance,
8 and that makes him a very dangerous person.
9 In my experience with these people I would
10 never turn my back on one of them. I would rather
11 turn my back on a Bengal Tiger.

12 Now, I could speak for hours
13 on marijuana, but I won't take up any more of
14 your time, except to agree with Mr. Blanchard,
15 that everything he said sounded reasonable and
16 plausible to me.

17 Thank you.

18 THE CHAIRMAN: Thank you.

19 Would you go to the microphone,
20 please?

21 THE PUBLIC: Mr. Blanchard,
22 you began your brief by stating that the
23 impression given of marijuana specifically, use
24 is not as widespread as, I think, the media,
25 you accused of building up this thing.

26 But what sort of figures do
27 you have for an indication of how widespread it
28 would be in Prince Edward Island?

29 ATTORNEY GENERAL BLANCHARD: I
30 haven't any specific figures. The^{law}/authorities

1 have given me this information in that it is
2 a minor proportion of the population of this
3 province.

4 THE PUBLIC: Well, how do
5 you tell this sort of thing, because people
6 aren't obviously going to tell an officer they are
7 smoking marijuana. If they do it, they do it
8 quite secretly. I mean, I don't see how you
9 can --

10 ATTORNEY GENERAL BLANCHARD: I
11 have given you my answer. I say I do not
12 have the figures.

13 THE PUBLIC: In what sense
14 do you use the word "addict"? I think you used
15 it in reference to users of mescaline and LSD
16 and I think marijuana as well.

17 ATTORNEY GENERAL BLANCHARD: I
18 think those aren't my words.

19 THE PUBLIC: I am not quoting
20 you. I am just paraphrasing what you said.

21 ATTORNEY GENERAL BLANCHARD:
22 I am quoting the word addict, an addict is a
23 person who is addicted, I would say.

24 THE PUBLIC: That is not a
25 very illuminating definition.

26 ATTORNEY GENERAL BLANCHARD:
27 If you want me to give medical definitions
28 I will.

29 THE PUBLIC: You have used
30 the word here.

1 ATTORNEY GENERAL BLANCHARD: I have
2 used it as a quote.

3 THE PUBLIC: Don't you think
4 that we already have a drug oriented culture
5 in a lot of ways?

6 ATTORNEY GENERAL BLANCHARD: No.
7 It depends on what your term "drugs" involve.

8 THE PUBLIC: Well, I
9 think there is this question of what is a drug
10 and what is an addict. It is ---

11 ATTORNEY GENERAL BLANCHARD:
12 Right.

13 THE PUBLIC: I notice that
14 right after you finished your brief, you pulled
15 out a cigarette?

16 ATTORNEY GENERAL BLANCHARD:
17 That's right.

18 THE PUBLIC: I think with the
19 widespread use of alcohol and tobacco we are
20 definitely a drug culture and I believe it is
21 benzadrine. I could be corrected. In the
22 United States the most wide users are housewives,
23 who are trying to reduce -- lose weight.

24 ATTORNEY GENERAL BLANCHARD: You
25 could be right.

26 THE PUBLIC: I think we
27 are in a culture and I think the culture of young
28 people who are using, say, marijuana, is not
29 necessarily the same culture as the people who are
30 using heroin and amphetamines, which, to my

1 understanding, are far more dangerous substances.
2 And you imply a causal relation
3 between using marijuana and heroin addicts.
4 You said in one survey 16 out of 20 heroin
5 addicts had used marijuana which I find, you
6 know, very easy to believe, because I imagine
7 these 16 people also used alcohol. They
8 probably maybe used LSD, may have used, you know,
9 any number of substances because the person who
10 uses heroin would probably have experimented with
11 many other substances as well. So I don't
12 think that proves a causal relation at all.

13 ATTORNEY GENERAL BLANCHARD:

14 Again, that statement was in a quote.

15 THE PUBLIC: This is a comment
16 I made.

17 I was rather displeased with
18 your use of a mode of language in your
19 presentation. I find it very (unintelligible)
20 You thought society should take⁵stand about
21 people who were "ingesting psychoactive drugs".
22 Well, it seems to me that could be more
23 simply and unemotionally put. I think taking
24 an aspirin is ingesting a psychoactive drug
25 or taking a weight reducing pill probably.
26 I am not a medical scientist, but it seems to
27 me that there are many other commonly used
28 substances which could be considered ingesting
29 a "psychoactive drug".

30 ATTORNEY GENERAL BLANCHARD: Again

1 I was quoting.

2 THE PUBLIC: Right.

3 Thank you.

4 THE CHAIRMAN: Gentleman
5 at the microphone?

6 THE PUBLIC: I am
7 representing the Charlottetown Interfaith
8 and have with me Reverend Gerald Tingley
9 who is representing the priest senate of the diocese
10 of Charlottetown, and we have to leave. We have
11 a brief prepared for you, and we will present you
12 with six copies for your members, but we would
13 like for a moment to summarize our position for
14 your benefit, we hope.

15 THE CHAIRMAN: I am sorry
16 that we have rushed you, but we have more briefs
17 that we can accommodate at the moment. Excuse me.

18 You go ahead.

19 THE PUBLIC: We want to get
20 on the floor at this time because we think we have
21 information very pertinent to the discussion and
22 questions at hand at this time. The dis-
23 cussion has centred itself in a sense around
24 the question, "does the government have the
25 right to step in on the person's freedom to
26 limit his ski-dooing or his marijuana?" And the
27 various other matters that have concerned
28 itself with it. There comes a time in the life of
29 a nation when government bodies, federal and
30 provincial, must take dynamic and positive action in the

1 name of the well being of the nation's citizens.
2 Now this action might take any of a number of forms;
3 financial, legislative and judicial. It must always
4 be based on an honest and objective concern for
5 the quality of individual and collective life.
6 The social structure is subject to change in many
7 ways and can become the source of negative influences
8 rather than positive ones. We feel the role of
9 government should be based solidly on the principle
10 of subsidiarity, that is, government should not
11 intervene when and where local organizations are
12 capable of taking action in the face of human problems.
13 This does not exclude entirely the possibility of
14 government offering to assist by offering advisory or
15 financial aid, but it does mean that as many
16 activities as possible should be carried out by
17 local bodies when and where these bodies are
18 capable of doing so.

19 Government must earnestly strive
20 to create that political, economic and social
21 framework in which man can act as a responsible
22 human being without the negative effects
23 of the structure impeding the development
24 of his full human potential. At the
25 same time government must work to overcome
26 man's inhumanity to man. Such conditions
27 of growth must be constructed. They do not
28 simply happen. And they must be protected
29 against destructive influences which, often in
30 the name of freedom, and authentic self-expression, are

1 detrimental to the growth of personal
2 maturity. ^{Second,} / sound judgment and true freedom
3 with its corollary of exercising responsibility.
4 The principle contribution of the federal
5 government must be the constructing and the
6 maintaining of conditions ^{con}ducive to strong
7 personal growth of citizens.

8 This atmosphere favouring
9 personal growth and development must be
10 advanced along all avenues and must receive
11 top priority in any considerations undertaken
12 at the ~~local~~ level. The positive
13 development of the people, taken from whatever
14 aspect one wishes to adopt, is in large measure
15 dependent ^{upon} / the conditions for development
16 which obtain ^{ed} / in that people's society.

17 Given the actual political
18 structure we enjoy in Canada, there are some
19 areas of concern and activity which pertain
20 to the federal level rather than to the provincial

21 Co-operation is certainly
22 desirable and necessary in the area of shared
23 responsibility and should, at the same time,
24 not be absent from the well defined particular areas despite
25 the danger ^{of meaningless} / overlapping and duplication. So
26 this must be guarded against at all times.

27 Canadian society, subject
28 as it is to the dynamic change and the gradual
29 unfolding of man's investigative history,
30 has a great deal to offer the average citizen.

At the same time, this society, like any other, has within its bosom, destructive factors. Some of these are the natural results of scientific advancement, not yet fully tested. Some spring from men and women who refuse to recognize and accept the rights of their fellow man. Some come from man's constant search for meaning and fulfilment.

armed
Government/ with its
vast research and information network,
must guarantee the Canadian public truth
concerning various products and services
not yet adequately safe for public use.
Citizens must act according to their individual
consciences and intelligent decisions are
rendered more likely when correct information
is available for consideration.

I call now on the Reverend
Gerald Tingley to continue. We have some
values and other recommendations to make
specifically.

THE CHAIRMAN: Thank you,
Attorney General Blanchard.

ATTORNEY GENERAL BLANCHARD: Mr.
Chairman, am I to remain here?

THE CHAIRMAN: I don't think -- I thought this might be addressed to you, sir, but I think we should release you. I thank you very much for the assistance you have given us this morning.

Thank you, Mr. Attorney.

ATTORNEY GENERAL BLANCHARD:

Thank you very much.

REVEREND TINGLEY: Mr.

Chairman, ladies and gentlemen, the second section of our brief deals with what we call human values, which we feel to be the basis of your investigation in the Canadian society. Full maturity in our society must include both freedom and responsibility as primary values. Anything less than the possibility of full human maturity is participation in poverty. We recognize that these values cannot be legislated but must be developed on the basis of individual maturity. They are important, because a free society ultimately must depend upon ^a good measure of freedom and responsibility to continue its existence and certainly ^{wrong} a/ use of drugs is a threat to individual freedom and responsibility.

Man, in exercising this freedom and responsibility, reveals his creativity which is a positive thrust towards a better personal and social life. This tremendous creative striving within man is greatly aided by the individual's level of maturity and sound relation to reality. It does not happen that human creativity is always exercised in a positive direction, this being due to the imperfection of man's

1 maturity and^{to}/intense social pressures from
2 one's fellows. The citizen is sometimes
3 inclined to involve himself in processes which
4 in fact are detrimental to his real growth and
5 development. Fooled into something
6 apparently good for him, man is hampered^{only}/rather
7 than aided in his search for authentic self
8 expression.

9 Review of responsible and
10 free person as one who can live in Canadian
11 society ^{through} / receiving from this society food,
12 shelter, education and broad social purpose
13 and responding by giving time, energy,
14 skill, knowledge and insight into a venture
15 of free citizenship, this venture is a full
16 and responsible agreement which will ultimately
17 be as good as the people who take part.

18 There are challenges within
19 our affluent society. To state only one,
20 seeing this venture outlined above as
21 an agreement to seek pleasure as a primary
22 value. Added to this are the great
23 changes in modern living which uproot the
24 individual from his environment and create a
25 need for support in the face of change,
26 a particular problem in Prince Edward Island.
27 Drugs are employed to satisfy this philo-
28 sophy on occasion and as a substitute for
29 adequate adjustment to change.

30 We lament, and we feel this point to be

1 extremely important, Mr. Chairman, we lament
2 that misplaced emphasis that is widely
3 found in Canada's educational enterprise
4 which accents how one is to make a living
5 rather than how one lives. This narrow
6 approach to education highlights the acquisition
7 of factual information frequently removed
8 from life and fails to instil the deeper
9 human values which are essential to
10 strong and mature personal living amidst the
11 many alienating forces of a technological
12 society. It is evident that many of our
13 present problems stem from man's inability to
14 cope with life rather than from his economic
15 incapacity to make a living, though the two are
16 not totally unrelated.

17 This failure to develop a
18 proper framework of life leads to meaninglessness,
19 and this lack of meaning is a major cause of his
20 search for fulfilment through the use of
21 drugs on occasion and other escape means.

22 "These "negative values"
23 threaten the traditional sources of strength.
24 In the past, we have relied upon the family,
25 the school, the church and the state to
26 develop this freedom of responsibility.
27 We stand for these sources of strength,
28 the social institutions which provide purpose
29 and meaning to life and help realize the
30 values of creativity, freedom and responsibility.

These are the values which constitute human maturity. These human values are essentially Christian values.

Speaking as Christian clergy, we believe that man becomes fully mature only to that degree he discovers and realizes his innate relationship to God through Christ. Any search for a mature humanity which by-passes this relationship is doomed to failure in its totality for it denies the God-man aspect of human existence.

Recommendations to the
Commission:

We do not see the non-medical use of drugs as helping in the development of the values contributing to human maturity. However, it is not sufficient to have legal control on the non-medical use of drugs. We must strive for a type of social order which helps the individual person to move quietly and quickly, to live responsibly above and beyond the law. As man in his nature is more than just an aspect of justice he must be able to grow in a system of control which teaches him to relate his whole nature properly.

Secondly, whereas the number of drug users is increasing in our country, and there are many factors not yet scientifically established regarding the effects of the non-medical use of drugs, of marijuana in particular,

1 its chemical composition, drug dependency,
2 personality deterioration, physical and psychological
3 effects, varieties of human response, et cetera,
4 we should like to call upon our government to have
5 continued and increased scientific research on the
6 effects of drugs in education and health agencies
7 and institutions by groups of experts in diverse
8 discipline.

9 Thirdly, we should like to call
10 upon government and public bodies to establish
11 resource centres in our country to provide
12 effective gathering and dissemination to the
13 Canadian public and in particular to teachers,
14 social workers, counsellors, families and youth
15 counsellors, of current information on drugs and
16 their effects and this could perhaps be done by
17 Information Canada.

18 Fourthly, we should also
19 recommend that immediate steps be taken in
20 establishing research and rehabilitation centres
21 for drug abusers and drug addicts, that
22 these centres be of easy access in the form of
23 drop-in centres, not to be connected directly
24 with court convictions, but have the definite
25 function of bringing the drug abuser back to
26 a constructive and useful life in society.

27 Fifthly, although we agree
28 that all drugs should be subject to some type of control,
29 whether internal on the part of the individual or external
30 on the part of society, a control which may vary with

1 each type of drug, and also, we should like
2 to see those who are pushing drugs prosecuted
3 to a greater extent than the ordinary user
4 and although we are not supporting the
5 advocates of the legalization of marijuana,
6 making it a free and unsupervised product
7 accessible to everybody, however realizing
8 that two thousand cases of use of marijuana
9 by young offenders were before our Canadian
10 Courts in 1969 in comparison with twenty
11 cases in 1962, and realizing that a criminal
12 record affects very deeply the useful
13 function of people in our present day society,
14 we recommend that (a) the federal laws
15 pertaining to marijuana be changed so that
16 the entire matter is not viewed as a Criminal
17 Code offence, but is subject to other more
18 appropriate legal controls, if these are
19 necessary. (b) and if the law is changed,
20 the criminal records of those who have
21 previous convictions be removed.

22 In conclusion, we want to
23 express our support, individually and
24 collectively, to the efforts of our government
25 to bring about in Canadian society those
26 positive conditions which will assist our
27 fellow citizens and ourselves to continue to
28 grow and develop as mature and responsible
29 decision making members of our society.

30 Thank you gentlemen very much.

1 THE CHAIRMAN: Thank
2 you very much.

3 I believe now that we will
4 have to adjourn as we go to the University of
5 Prince Edward Island, for^{an} informal hearing on campus
6 there, and we will return at two-thirty.

7 I must apologize to certain
8 people we have not been able to hear this morning ,
9 particularly Professor Decarie, and I
10 hope you will be back this afternoon. We will
11 certainly be grateful if you can do so,
12 because we have a number of briefs this
13 afternoon, and we will stay here as long as
14 necessary to hear from everyone who wants to
15 help us. But we will be back here at two-
16 thirty.

17 Now we go to the University.
18 ---Upon adjourning at 12:25 p.m.

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1 --- Upon re-convening at 2:30 p.m.

2 THE CHAIRMAN: Ladies
3 and gentlemen, I call to order the hearing
4 of the Commission of Inquiry into the non-
5 medical use of drugs. We have just come
6 from the university where we heard a most
7 interesting discussion from the students.

8 We try to avoid
9 comparisons in observations as we go across
10 the country, but I don't mean to detract
11 from anyone else when I say that we have been
12 so very favourably impressed by the student
13 body discussion we heard and the general
14 atmosphere of free intellectual exchange which
15 have been seems to / developed and stimulated in this
16 university. "I don't know just how you are
17 as doing it", / I said to the Dean, "but whatever
18 is being done is pretty impressive." So we
19 stayed a little longer than we anticipated
20 and I apologize to all of you for keeping you
21 waiting.

22 Now, we have quite a long
23 list of submission scheduled for this afternoon.
24 I should first ask if Professor Decarie is
25 here, and we are much obliged to him for having
26 waited. He was scheduled to speak this morning.

27 PROFESSOR DECARIE: You
28 can feel obliged to me on two counts. It is
29 a very brief submission, five pages, double-
30 spaced. I'm sorry I could not provide you with

1 references. I'm not sure anyone reads
2 them, but in any event, I couldn't, since
3 most of the material I used was material I
4 had found in Ontario, and I didn't have time
5 to get it down here.

6 In considering the
7 desirability of the legalization of the use
8 and sale of some drugs, this Commission might
9 reflect on previous Canadian experience in
10 a closely related field. Since about 1830,
11 there has been a series of movements to pro-
12 hibit the sale of alcoholic beverages in Canada.
13 Most provinces enacted prohibition measures
14 between 1901 and 1918 and most of them abandoned
15 prohibition in favour of government monopoly
16 of sale during the 1920's.

17 It is true that it is
18 unwise to assume that history is an infallible
19 guide to the future; but it's also true that
20 many of us, even as we protest, will persist
21 in making something very like that assumption.
22 Since that is the case, and since history can
23 be of some value in planning future action,
24 this Commission might consider Canada's ex-
25 perience of prohibition of alcohol.

26 I might add as a parenthesis
27 that if this Commission would look at the
28 records of the Royal Commission on the alcohol
29 problem for 1895, they could save themselves a
30 great deal of time since virtually every argument

1 I have heard presented before this Commission
2 was presented at that Royal Commission, and
3 one has only to change some of the nouns to
4 have what will probably be a complete record
5 of this Commission's findings.

6 No doubt, the Commission
7 has already at many times heard the claim
8 that the prohibition of alcohol was a failure
9 and that the prohibition of popular drugs
10 must also be a failure. In fact, very little
11 is known about the effectiveness of prohibition
12 in Canada. What is taken as fact is a large
13 body of folk-lore, much of it derived from
14 tales of prohibition in the United States -
15 and even those of doubtful validity. The sum
16 of these tales is that prohibition was un-
17 enforceable and even counter-productive.

18 The commonest example given
19 of the counter-productivity of prohibition is
20 that it introduced many to alcohol who had
21 never used it before. Presumably, this belief
22 is based on the fact that per capita consumption
23 of alcohol in Canada was greater after the
24 prohibition experiment than it had been before.
25 But alcohol consumption had begun to rise a
26 few years before prohibition and the post-
27 prohibition rise may have been no more than a
28 continuation of an existing trend. Whether
29 prohibition encouraged or reversed that trend
30 is not known.

1 As to enforceability,
2 most evidence cited is based on two popular
3 beliefs; that arrests for drunkenness rose
4 during the prohibition period and that the
5 electorate turned against prohibition when
6 it was realized that it had failed.

7 But, whether law enforce-
8 ment was a greater problem during or after
9 prohibition is still a matter for conjecture.
10 Statistics of arrests are notoriously unreliable
11 since they do not reflect the varying attitudes
12 of police forces; some were hostile to prohi-
13 bition and were reluctant to make arrests while
14 others zealously supported prohibition and made
15 arrests at every opportunity. Another problem
16 in interpreting such statistics is the range
17 of discretion which was permitted in laying
18 charges; drunken conduct might be charged as
19 disorderly conduct. Another difficulty is
20 raised in the case of an offence being handled
21 by two or more police forces. Such an offence
22 might be recorded in statistics as two or more
23 offences. So misleading were statistics for
24 arrests that both prohibitionists and anti-
25 prohibitionists were able to use them in
26 support of their positions.

27 It is worth remembering,
28 too, that statistics do little to reveal the
29 incidence of liquor-related offences as distinct
30 from offences against liquor legislation.

When prohibition was repealed, alcohol became available to most of those who wished to use it. However, in the conflict over drug use, age seems to be a far more important factor with the young tending to be prominent among those who favour the legalization of the sale of some drugs. It is inconceivable that there, /and I apologize for a spelling mistake there -- it is inconceivable that there could be legalization of drugs for those under the age of eighteen so that a large number of users would not be affected, legally, by the change. With drugs available on the legal market, this younger group would create an impossible enforcement problem. It would be as though alcohol had been made legal for middle class Canadians while remaining prohibited for those of the working classes.

The second item of evidence

1 against the enforceability of prohibition;
2 that the electorate turned against it, also
3 falls under some shadow of doubt. I have
4 detailed information/respect/only Ontario,
5 but, there, the electorate upheld prohibition
6 in two plebiscites, in 1919 and 1924. When
7 the government of Ontario finally repealed
8 prohibition in 1927, it did so without risking
9 another plebiscite. There is reason to believe
10 that, as late as 1941, no more than one-third
11 of the population of Ontario was opposed to
12 prohibition; one-third favoured it, and one-
13 third had no opinion. This information is
14 contained in the report on a survey conducted
15 for the brewers of Ontario. That report, by
16 the way, is in the archives of Labatt's Brewery.
17 The report also indicated that almost all of
18 the daily press of Ontario would have favoured
19 prohibition legislation at that time. Prohibition
20 may have been a failure but, evidently, many
21 of the people who had experienced it did not
22 think so.

23 As provinces decided to
24 legalize the retail sale of alcoholic beverages,
25 they chose, for the most part, to carry on such
26 sale through the agency of government monopolies.
27 The motive was probably to increase government
28 revenues at a time when provincial government
29 expenditures were becoming pressed by the
30 soaring demands of road building and education.

1 But that motive was rarely expressed in public.
2 Instead, government monopoly was publicized
3 as a means of controlling the evils of alcohol
4 and the government agency which was to carry
5 out the retail sale was commonly referred to
6 as a "control" board. This terminology is
7 significant for it reflected the general
8 opinion of the electorate that alcohol was
9 harmful and that its use should be restricted.

10 The manner in which con-
11 trols were to be achieved were never very
12 clear. It was said that government sale would
13 avoid the evils of private sale since govern-
14 ments were innocent of the profit motive and
15 there was a vague suggestion that control
16 boards would, somehow, discourage the use of
17 alcohol. But the mechanism was never as
18 important as the magic word "control". The
19 impression was given that control was something
20 very like prohibition and that impression was
21 probably a factor in preventing a major public
22 outcry as prohibition was removed from the
23 statute books.

24 Since then, events have
25 shown that government control is remarkably
26 like government sale and that government sale
27 is remarkably like private sale. Certainly,
28 there has been no evident tendency to a
29 reduction in alcohol use since the advent of
30 government control. Government control has not

1 even resulted in the allotment of alcohol
2 revenues to the treatment of alcohol problems.
3 Rather, the profits from alcohol sales have
4 been absorbed into the general revenues of
5 the provinces and have been subject to the
6 same spending priorities as other revenues.
7 In short, government control of the retail
8 sale of alcohol has been little more than
9 a thinly disguised method of indirect taxation.

10 The Canadian experience
11 of prohibition may have some relevance to
12 the work of this Commission. First, the
13 experience suggests that popular notions
14 about the effectiveness of prohibition may
15 be fallacious. Secondly, it suggests that
16 much scholarly debate about such an issue
17 may be wishful thinking in disguise. Thirdly,
18 it suggests that any action is less likely
19 to solve a problem than it is to substitute
20 one problem for another.

21 Finally, there is an
22 important political lesson to be learned
23 from the struggle over prohibition. From the
24 1850's to the 1920's provincial and federal
25 parties used prohibition as a political football,
26 evading any responsibility for decision through
27 a series of plebiscites, referenda and Royal
28 Commissions. This behaviour seriously weakened
29 popular trust in those parties and it played
30 a part in the rise of minor parties during the

1 1920's and 1930's. It even caused many
2 Canadians to question of the worth of the
3 parliamentary system of government and to
4 demand alternatives. It is surely un-
5 necessary to draw the moral from this.

6 THE CHAIRMAN: Thank you,
7 Professor. You are Professor Decarie?

8 PROFESSOR DECARIE: I hope
9 so.

10 MR. STEIN: Could you
11 expand, on page 2 of your brief, in the last
12 paragraph, exactly what you mean by the
13 sentence, "If so much is uncertain about the
14 problem of enforcement of liquor legislation,
15 there can be a measure of certainty on at
16 least one point", that "Liquor legislation,
17 after prohibition had been repealed, was more
18 enforceable than drug legislation would be if
19 some drugs were to become legally salable".

20 PROFESSOR DECARIE: What-
21 ever liquor legislation survived after that
22 point, there ~~was~~ still some legislation affecting
23 liquor. One couldn't, for example, drive a
24 car while drunk -- that sort of thing. And
25 difficult as that is to enforce, it is probably
26 much easier to enforce than it would be to
27 enforce drug legislation which would be
28 directed against minors, presumably, if drugs
29 were made legally salable.

30 MR. STEIN: What is the

1 basis of your view?

2 PROFESSOR DECARIE: Well,
3 yes, the quarrel over liquor, I think, was
4 very largely a bit of class warfare. It was
5 the means of working classes challenging the
6 dominance of middle classes in society. How-
7 ever, when liquor was legalized, it was
8 legalized for all of those who wanted it.

9 Now, I think it most un-
10 likely that you could do the same thing for
11 drugs. It is not conceivable that government
12 could legalize the sale of drugs below the age
13 of twenty-one, or possibly, eighteen.

14 MR. STEIN: I think I
15 follow you. What your point appears to be is
16 that the age group involved is a very different
17 one, and that the drugs would be used by a
18 different age group. Is this the point?

19 PROFESSOR DECARIE: Yes.
20 The drugs are evidently in large demand by
21 a younger age group and this was not the case
22 with alcohol.

23 MR. STEIN: Could I ask
24 you, is it your view that there is less control
25 now with this particular age group, than there
26 might be under a situation where the drugs
27 were made legally available? Is it your
28 contention that there is less control?

29 PROFESSOR DECARIE: I don't
30 think ---

1 MR. STEIN: You see, I am
2 trying to understand what your view would be
3 as to the present nature of control. Are you
4 suggesting that making the drug legally
5 available and attempting to control it through
6 some kind of regulatory prohibition would be
7 less control than presently exists where we
8 have prohibition?

9 PROFESSOR DECARIE: Yes,
10 there is no doubt in my mind about that at all.

11 THE CHAIRMAN: Just pursuing
12 this exchange with Mr. Stein, Professor Decarie,
13 the provincial legislation, which provides for
14 the legal availability of liquor, has provisions
15 respecting prohibiting the sale of liquor to
16 minors. Now, are you -- and if one were to
17 assume a similar prohibition of sale of some
18 drugs which might be made legally available,
19 is it your feeling that it would be more
20 difficult to enforce that prohibition of the
21 sale to minors in the case of some other drug
22 than alcohol?

23 PROFESSOR DECARIE: I think
24 it would be considerably more difficult.

25 THE CHAIRMAN: Why is that?

26 PROFESSOR DECARIE: Because
27 alcohol right now isn't being used as a weapon
28 to challenge various establishments the way
29 that drugs are. Alcohol had that use at one
30 time, though it was never a case of being used

1 as youth against age, it was a case of
2 working class. We are in quite a different
3 situation with drugs.

4 THE CHAIRMAN: Is it
5 your impression that the prohibition against
6 the sale of alcohol to minors is being
7 effectively enforced now?

8 PROFESSOR DECARIE: I don't
9 know what the ---

10 THE CHAIRMAN: What is
11 your assumption when you are making the
12 comparison as to the present enforceability?

13 PROFESSOR DECARIE: I don't
14 think that alcohol in anything like a steady
15 diet reaches a very large number of minors,
16 certainly not until the ages of sixteen or
17 seventeen or so. And I don't know of any
18 figures to support this sort of thing. One
19 has to go on what one sees or hears and it
20 has not been my impression ---

21 THE CHAIRMAN: We have
22 been told it is the drug most used by minors.

23 PROFESSOR DECARIE: It may
24 be. I would like to know the source of the
25 figures, by the person who is doing that.

26 THE CHAIRMAN: We have
27 been given some survey data and that opinion
28 has never seriously been challenged. That
29 assumption has never seriously been challenged,
30 that is, it is the most prevalent drug in all

1 age groups, alcohol.

2 PROFESSOR DECARIE: But it is
3 an assumption?

4 THE CHAIRMAN: It is an
5 assumption based on statements and data that
6 has been turned up in some surveys. I just
7 mentioned that this is said and assumed, I believe.

8 I am interested if you yourself
9 have a contrary assumption.

10 PROFESSOR DECARIE: And it is
11 just an assumption.

12 THE CHAIRMAN: Yes. But then I
13 take it that you would assume that if serious
14 consideration were given to make any other drug
15 legally available, you assume that there would
16 have to be an age limit?

17 PROFESSOR DECARIE: I presume that
18 if only for political reasons, the government
19 places an age on it.

20 THE CHAIRMAN: What I really want to
21 get, you are telling us--you are giving us a
22 historical perspective. I want to get something
23 tributary to you here. I take it you are not
24 arguing the merits of any particular change in
25 the present drug laws?

26 PROFESSOR DECARIE: No, I am not.

27 THE CHAIRMAN: Right. But you
28 are observing, you are making an observation, as
29 I understand it, on the enforceability of
30

1 post-prohibition legislation which makes
2 a drug legally available with some attempted
3 limits as to age. Is that the burden of your
4 message?

5 PROFESSOR DECARIE: There
6 are two things, I think. That is one of them.
7 And another is, a great many hopes that are
8 placed on the change if legislation really
9 doesn't materialize, or they didn't in this case.

10 THE CHAIRMAN: What were
11 the hopes and what would you think the hopes
12 are among the advocates today of change? What
13 were the hopes?

14 PROFESSOR DECARIE: One
15 heard, for example, that beer should be legalized
16 because this would stop the demand for harder
17 liquor. That is sort of a parallel of the
18 same sort of thing one hears today.

19 And, of course, what it
20 really turned out to be was a wedge to get the
21 door open to broaden the sale of alcoholic
22 beverages. And I think the experience also
23 indicated that the -- the argument was also
24 made that the government would not have profit
25 motives and therefore would not encourage the
26 sale of alcoholic beverages, and the government
27 does of course have profit motives, rather
28 important ones, in the case of liquor control.

29 THE CHAIRMAN: Yes. Dean
30 Campbell?

1 MR. CAMPBELL: I was barely
2 born during Prohibition, and I have no active
3 memory of the debate. But I was old enough to
4 remember some of the debate that took place in
5 New Brunswick at the time that there was a
6 Commission of Inquiry, or a Royal Commission,
7 on the legislation there. At that time, liquor
8 was available only, in that case, in/^a"government
9 store", but not available by the glass.

10 One of the arguments that
11 was quite frequently raised during that debate
12 was that the sale of liquor by the glass would
13 provide a means really of quality control. Now,
14 this was quality of the setting, quality of
15 sanitary arrangements, for instance. Because
16 during the period prior to the change of the
17 law in New Brunswick, I lived in Sackville, and
18 I think there were four, or perhaps five, fairly
19 open bars. I think there were some forty-five
20 or so in Moncton. They were pubs.

21 I think there is a feeling
22 that control, actually of premises and the
23 surroundings of the use of/^{the}drug, alcohol, has
24 increased as a result of that particular change
25 of legislation. Now, this isn't a perfect
26 analogy. Are you aware, as I gather you studied
27 the question of the prohibition debates, was
28 there much debate at that time in favour of
29 legalization on the grounds to control quality
30 of liquor?

1 PROFESSOR DECARIE: Yes, very
2 much. In fact that argument entered into it
3 even before Prohibition became a thought.
4 There was a great deal of this discussion of
5 control of the quality of the liquor, which
6 didn't impress the prohibitionists because they
7 thought the stuff was all poison anyway, and there
8 was a lot of talk about control though, in a much
9 vaguer sense.

10 The impression was given that
11 government was talking about controlling the
12 quantity of liquor, controlling those who would
13 receive it; that sort of thing. And this was
14 the part that turned out to be an illusion.

15 MR. CAMPBELL: There wasn't any
16 advocacy of the repeal of prohibition on the
17 grounds that people would get ethyl alcohol
18 rather than wood alcohol?

19 PROFESSOR DECARIE: Oh yes, this
20 argument was used, although I suspect it wasn't
21 terribly important.

22 MR. CAMPBELL: I was thinking
23 that perhaps was a hope.

24 PROFESSOR DECARIE: Yes. Much
25 of my reports, of course, were in the earlier
26 period, in which the question of what precisely
27 they were drinking wasn't important but whether
28 were drinking at all.

29 MR. STEIN: You made a
30 point a while ago about whether there was a

1 significance in drugs in that they would be
2 more likely to be attractive to the young
3 because of their symbolic significance
4 which apparently alcohol didn't have.

5 PROFESSOR DECARIE: Alcohol
6 did have, but not on the same basis.

7 MR. STEIN: Now, do you
8 think, or would you venture any opinion on
9 the effect of legalizing the drug in terms
10 of maintaining its present symbolic significance,
11 presuming it has any?

12 PROFESSOR DECARIE: Well,
13 here again, I can only look for some parallel
14 in prohibition which is a pretty haphazard
15 way of doing this.

16 I am not aware that alcohol
17 has lost any of this desirability for people
18 in the working class just because it has lost
19 its symbolic value. So I suspect the same
20 thing would be true here. I think it would
21 remain as popular as ever. However popular
22 that is.

23 MR. STEIN: In other words,
24 the basis for the attraction to the drug isn't
25 its symbolic value?

26 PROFESSOR DECARIE: I think
27 once it comes into common use, then it will
28 probably stay in common use if it is legalized.

29 DR. LEHMANN: What about
30 the argument that organized crime was encouraged

1 or emerged mainly because of prohibition
2 and was somewhat in use after prohibition?
3 Is that true or not?

4 PROFESSOR DECARIE: This
5 is a bit of a folk-tale I was talking about.
6 You know, one hears of stories of fantastic
7 rates of crimes, and I have certainly found
8 stories of local police forces who looked
9 for gangs of smugglers, and even some
10 in Canadian governments because the
11 smuggling of alcohol was a rather important
12 source of dollars for Canada. To what extent
13 we have proof that organized crime flourished,
14 I don't know. I haven't seen very much proof.

15 THE CHAIRMAN: Professor
16 Silverman?

17 PROFESSOR SILVERMAN: Yes.
18 I was very pleased to hear this presentation
19 by my colleague, Professor Decarie. Unfortunately,
20 I missed the first part of it. I have one
21 comment to make, and a question to ask with
22 perhaps more of an historical significance than
23 in terms of the Commission hearing, but I hope
24 you will indulge me on this.

25 The comment is that I was
26 interested in what you said about the Ontario
27 government having faced two plebiscites on this,
28 where prohibition was sustained, and then
29 changing the law without going to a third
30 plebiscite.

1 Most of one's reading,
2 just casual reading, isn't as expertly
3 involved in this as Professor Decarie is,
4 as with regards to the American prohibition.
5 It seems to me I recall some place, I believe
6 it is Arthur Schlesinger's first volume of
7 his "Age of Roosevelt" which surveys the 1920's,
8 where Schlezinger, in a chapter on prohibition,
9 puts forward the argument -- I don't know
10 whether he really has a base on this synthesizing
11 and what -- to the effect that historians in
12 the United States generally accepted that very
13 many of the plebiscites sustained prohibition
14 or called for prohibition, and they interpreted
15 this to mean the people were quite willing to
16 vote for prohibition, knowing that if they
17 wanted to get some booze, that it was relatively
18 easy to get it with or without the prohibition.

19 In other words, I think it
20 is Schlesinger, I couldn't swear to this, that
21 Schlesinger compares this to a sort of human
22 desire to want to have your cake and eat it
23 too, to adopt a certain stand on the surface
24 and then say, "Well, when I am breaking this,
25 you know, that is neither here nor there".

26 But I think this would be
27 worth looking into.

28 The second thing that I am
29 interested in; maybe you have this in the
30 beginning of your presentation, so I apologize,

1 is whether you have data worked out on the
2 cost of the Ontario prohibition laws. I would
3 be interested in knowing what, if you will,
4 the unit cost was on the average during the
5 period of prohibition. In other words, how
6 much was spent on additional police enforcement
7 procedures, viz a viz say, each conviction
8 or each apprehension, because I think this
9 is an important point in general terms of
10 government actions and that is, whether a
11 particular law gives you, if you will, the
12 greatest cost, effectiveness, or social
13 benefit, effectiveness in terms of its enforce-
14 ment promotion.

15 THE CHAIRMAN: Thank you.

16 PROFESSOR DECARIE: It would
17 be very difficult to answer that latter point
18 without a monstrous study, which is not
19 necessarily to be interpreted as a study of
20 monsters; it is something like it. The
21 government studies and figures on arrests are
22 really hopeless things. There are so many
23 variables in them and there are so many variables
24 in cost, which would be very difficult to tangle
25 with.

26 There was a government
27 sympathetic to prohibition after the very first
28 time in Ontario, followed by one unsympathetic
29 to prohibition, and then there would be diffi-
30 culties in determining those costs in relation

1 to reorganizations that were going on in the
2 police force at the time, and the avrying attitudes
3 of local police forces. It sound worth trying,
4 but I am just not sure how it could be done.

5 THE CHAIRMAN: Would you like
6 to go to the microphone, please?

7 THE PUBLIC: I just have two
8 short questions for Graham.

9 The first one is, do you think
10 there would be any advantage in legalizing
11 marijuana so as to get a regulated standard of
12 quality?

13 PROFESSOR DECARIE: Well, this
14 depends on whether it is found that marijuana
15 is at all harmful. If it is harmful then it is
16 like finding some decent standard for rat poison.
17 It it is not harmful, then perhaps it might make
18 sense.

19 THE PUBLIC: Do you see a causal
20 relation between using marijuana and goind into
21 harder drugs. You have implied a causal relation
22 between beer and alcohol. Do you think the
23 analogy holds up when you go into other drugs--
24 marijuana and heroin, for instance?

25 PROFESSOR DECARIE: I have no
26 idea, no.

27 THE PUBLIC: Do you have any
28 personal opinion on this?

29 PROFESSOR: No.
30

1 THE CHAIRMAN: Are there any
2 comments? If not, thank you very much,
3 Professor Decarie.

4 PROFESSOR DECARIE: Thank you.

5 THE CHAIRMAN: We call now on the
6 Alcohol Association.

7 THE PUBLIC: I wonder, Mr. Chairman,
8 if I may ask a general question of the Commission.
9 I have this marked here.

10 THE CHAIRMAN: Is that the answer
11 you have in your hand?

12 THE PUBLIC: No.

13 THE CHAIRMAN: Did you give a
14 notice of it?

15 THE PUBLIC: No Mr. Chairman, it
16 is simply that Mr. (Mather) in last Monday's
17 (answer), raised the question of whether the non-
18 medical use of marijuana would be referred to the
19 Standing Committee of Health, Welfare & Social
20 Affairs, and this question was just simply to take
21 a note of it, and that is just by way of preface.

22 I wonder if the Chairman could make
23 a point on this, being that we heard a number of
24 statements coming out of Ottawa, what understanding
25 the Commission has with the government as to its
26 relevance? Do you have some sort of understanding
27 that basic changes in the laws are not going to be
28 undertaken through some other agencies until you
29
30

1 have the chance to report--I'm not trying to
2 put anybody on the spot.

3 THE CHAIRMAN: Well, you are
4 doing it most effectively, If you could
5 clear the room of the press, I might start to
6 think seriously about formulating an answer
7 that I can live with. I think, actually, I
8 can't avoid the question because you have put
9 it forward.

10 THE PUBLIC: I am sorry.

11 THE CHAIRMAN: That is all
12 right. You are doing your job. I wouldn't
13 mind if you came up here now and advised me
14 how to answer it.

15 We are an independent Commission
16 of Inquiry. We have done everything reasonably
17 possible to assure not only the reality of our
18 independence but the appearance of our
19 independence.

20 We have received our terms of
21 reference, we have analyzed our terms of reference
22 without assistance from anyone in government. We
23 have come to conclusions as to what they require
24 of us, and we are doing our conscientious best
25 to carry them out.

26 THE PUBLIC: May I just make
27 one furtherpoint? Since the Commission might
28 convey this back in its report--that I personally,
29 as I said, just got involved in this, it is not
30 something I do all the time. And I personally

1 take exception to the comment made a week
2 or two weeks ago by Mr. McIlrath, the Solicitor-
3 General, about a small group of professors
4 having an interest in this. It would seem to
5 me, I would like to see this conveyed back --
6 it would seem to me that this kind of comment,
7 while it is fair comment to criticize either
8 way, this kind of comment, if he was quoted
9 correctly, is the kind of thing that inhibits
10 people from coming up before a committee of
11 this sort. Thank you, sir.

12 THE CHAIRMAN: Thank you.
13 I must say this, that it is consistent with
14 what I said earlier, that we do not make any
15 representations to anyone about such comments,
16 whatever our own views of them may be. We are
17 going our way to the best of our ability, and
18 it is my judgment at this stage that we are
19 better to ignore all comments.

20 I call now, excuse me, on
21 Dr. Killorn.

22 DR. KILLORN: On behalf
23 of the Alcoholism Foundation of P.E.I., we wish
24 to thank the Commission investigating the non-
25 medical use of drugs for giving us the opportunity
26 of presenting our observations on the abuse of
27 prescriptions, sedative drugs in relation to
28 alcoholism.

29 In this presentation, when
30 we refer to sedative, we are speaking of any

1 chemical substance whose action, mild or
2 strong, is to depress or level off the mood
3 of the individual ingesting the substance.

4 For orientation, it should
5 be noted that alcohol is only one of a group
6 of sedative drugs or soporifics which include
7 liquid substances such as paraldehyde and
8 chloral hydrate, solid drugs such as the barbi-
9 turates and tranquilizers and gases such as
10 ether, chloroform, cyco-propane, etc. These
11 drugs are not narcotics, which are used in
12 medicine to alleviate pain but do not necessarily
13 put one to sleep. The soporifics don't do
14 anything against pain but they do put one to
15 sleep. They all belong to one group of com-
16 pounds, the members of which possess similar
17 pharmacological behaviour. They may differ
18 quantitatively in how quickly they may start to
19 act and how long they last; but they are all
20 sedative drugs with the same quantitative
21 effects. They are also all addicting drugs
22 when the proper circumstances are present in
23 the individual taking them. By addiction we
24 refer to a circumstance by which a drug has
25 been used and is now gone from the body but
26 has resulted in an organic measurable disease
27 state, a condition which demands more drug in
28 order to get relief.

29 Alcohol is the oldest known
30 drug of addiction and in alcoholism treatment

1 we have been mainly concerned with its abuse.
2 However, it has become very obvious to us,
3 and is well known in other alcoholism centres
4 throughout the country, that alcoholics are
5 prone to seek chemical comfort in any manner
6 and their dependence on alcohol can be easily
7 transferred to other sedatives either in liquid,
8 pill or capsule form. This transference, in
9 our experience, usually leads to addiction to
10 the other sedative drugs besides alcohol.

11 We have found in our short
12 experience that upwards to 80% to 90% of our
13 patients have been exposed to these sedatives,
14 and that many have developed a marked dependence.
15 To illustrate the similarity between alcohol
16 and these sedative drugs, one has only to view
17 the withdrawal state of a few patients. We have
18 seen the withdrawal state from alcohol mimicked
19 in its entirety even up to the development of
20 delerium tremens and convulsions during the
21 withdrawal from these so-called non-addicting
22 minor tranquilizers.

23 The reason why alcohol alone,
24 rather than one of the other sedatives, has
25 become the basis for the title of a disease,
26 namely alcoholism, is due to the fact that it
27 was the first of the sedatives to be discovered
28 and that it has always been used socially. It
29 is easily available without a prescription,
30 without a physician, and has become interwoven

1 with the fabric of our society and our social
2 functioning. However, we in the Alcoholism
3 Foundation of P.E.I., believe that a more
4 correct name for the entire disorder would
5 actually be "sedativism". This disorder would
6 signify addiction to any one or all of the
7 soporifics.

8 The names of the other
9 drugs included in this group along with alcohol
10 should be mentioned at this point, because
11 evidently, there are many who feel that the
12 use of these drugs in the treatment of alcoholism
13 is of benefit. Not only do we believe that this
14 procedure is of no benefit, but we believe that
15 it is actually an extremely dangerous matter,
16 not only to the individual himself, but to
17 society as a whole; to transfer the alcoholic's
18 dependency to a sedative drug or to sleeping
19 pills.

20 The drugs which should be
21 noted by trade name are sleeping pills such
22 as seconol, nebutol, carbitol, etc., so-called
23 "goof balls" by the young; "minor tranquilizers"
24 such as librium, valium, aquinol, doriden, etc.,
25 and, as was mentioned previously, liquid sedatives
26 such as peraldehyde and chloral hydrate. It
27 should be clearly understood that we are not
28 concerned with the use of these drugs in the
29 non-addictive type of individual any more than
30 we are concerned with the use of alcohol in the

1 individual who belongs to the 14 out of 15
2 drinkers who can control its use. It is only
3 to those individuals who are mentioned previously, who
4 are subject to addiction, that we feel some
5 mechanism should be established to control
6 their abuse of these sedative drugs.

7 It is our contention that
8 the simple act of prescribing sedatives in order
9 to relieve the anxiety symptoms of the alcoholic
10 patient is the one thing that will guarantee
11 failure almost 100% of the time. If an indi-
12 vidual has a huge tolerance for alcohol then
13 obviously it will require far more than the usual
14 prescribed amount of the sedative drugs to
15 procure, for the alcoholic, the effects he desires.

16 In contrast with some of the
17 other materials which have been discussed under
18 the general heading of the non-medical use of
19 drugs, these drugs which we are discussing are
20 lethal. Suicides using these materials are
21 common. Accidental overdosage, either with or
22 without the use of alcohol in the alcoholic
23 has caused death. Many otherwise unexplained
24 fatal or non-fatal automobile accidents are
25 due to the abuse of these drugs by the driver.
26 Industrial accidents may be common since it
27 is obvious that a person under an overdose of
28 this type of medication cannot be functioning
29 normally in his job. We feel that many other
30 examples may be given but that these few are

The important matter to

It is obvious that with

visitation to different physicians and different pharmacists that the pharmacies and the sedativists may abuse the medication for an extremely long period of time. The patient will usually state that the physician told him that this is an absolutely non-addictive medicine in spite of

1 the fact that the patient himself knows better.
2 Very few will admit that they are "pill takers"
3 since their definition of a pill taker is one
4 who takes barbiturates or other drugs by the
5 handful. And of course this definition lets
6 him off the hook. However, we find in our
7 withdrawal unit that the usual question after
8 denial of medication involvement is: "What are
9 you going to give me for my nerves and to sleep
10 tonight?"

11 The second area where these
12 drugs may be obtained are in the so-called
13 "black market". When statements are made by
14 patients such as, "I could go downtown and get
15 50 carbitols right now", or "I know where I can
16 get any number of librium 25s", etc., then we
17 are well aware that these drugs are available
18 outside of pharmacies. We read of vigorous
19 detection and prosecution methods used by the
20 authorities to deter the abuse of other materials,
21 but up to this moment we have not noted any
22 activity in the above-mentioned area.

23 Accordingly, we would
24 strongly recommend to this Commission that
25 some mechanism be set up either federally or
26 provincially to control the abuse of these
27 dangerous sedative drugs.

28 Firstly, we would suggest
29 that when a private physician or the Alcoholism
30 Treatment Centre discover that they are dealing

1 with a sedative addict, an appropriate appointed
2 committee of the Pharmacy Association would be
3 so informed. The person's name and that of the
4 informant should be recorded and all druggists
5 and pharmacies throughout the province should
6 be notified.

7 Now, when this individual
8 appears with a legitimate prescription from an
9 unknowing physician the druggist should be
10 required to inform the physician of the status
11 of his patient regarding the sedative drugs,
12 also inform the involved physician of the agency
13 which has informed the Pharmacy Association of
14 the problem. The physician would then be
15 requested to contact the informing agent or
16 agency before the prescription is filled in
17 order that all of the facts may be available to
18 him. This may appear as an infringement of the
19 individual rights of the physician and his
20 patient, but since it is felt that the problem
21 is becoming rapidly more prevalent and dangerous
22 and if there is any wish on the part of society
23 as a whole to improve the situation, it cannot
24 be left to individual judgment.

25 Secondly, we would request
26 that the federal authorities take a more
27 aggressive attitude towards the prosecution and
28 control of the non-medical sources of these
29 compounds. We feel that in a small area such
30 as Prince Edward Island, this discovery should not

1 be particularly difficult.

2 Again we wish to reiterate
3 that abuse of prescription sedative drugs is
4 a serious problem and one that has up to this
5 point been lightly considered both by individuals
6 and by the authorities. We know that our efforts
7 to control the problem of alcoholism on Prince
8 Edward Island would be greatly assisted by the
9 implementation of the above recommendations for
10 the control of the abuse of these other sedative
11 materials.

12 We thank you again for giving
13 us this opportunity of placing this problem
14 before the Commission and also for your kind
15 attention to our presentation.

16 THE CHAIRMAN: Thank you
17 very much, Dr. Killorn.

18 Are there questions?

19 Professor Bertrand?

20 Excuse me, there is a gentle-
21 man at the back. Would you like to come to the
22 microphone?

23 THE PUBLIC: I don't want to
24 take nobody off no where, or, nothing like that,
25 but I was wondering about the bootleggers that
26 are selling rubbing alcohol and all that, and are
27 making it mix and all that. It is very hard ---

28 THE CHAIRMAN: Bootleggers
29 selling rubbing alcohol?

30 THE PUBLIC: Rubbing alcohol,

1 || 50¢ mix.

2 THE CHAIRMAN: How does
3 one have to deal with that?

4 THE PUBLIC: I am not an
5 alcoholic, or anything like that, but I did,
6 I really did. ---

7 THE CHAIRMAN: Speaking
8 generally and not speaking of anyone's personal
9 experience.

THE PUBLIC: OK then, I will speak generally. I am not telling Dr. Killorn off, he is a good doctor, and he is one of my doctors. He is my doctor. But still, you can go into a drug store, and still get rubbing alcohol, ^{without} prescription. But you have got to go in, and I know in my own heart that it shouldn't be allowed.

18 THE CHAIRMAN: Well, rubbing
19 alcohol has kind of a medicinal use.

20 THE PUBLIC: It is a different
21 kind of rubbing alcohol.

22 THE CHAIRMAN: How do you
23 think it should be controlled? It presumably
24 has to be available ---

25 THE PUBLIC: It should be
26 controlled to a certain extent through prescription,
27 the same as the doctor has said.

28 THE CHAIRMAN: I see. You
29 feel ---

30 THE PUBLIC: You should have

1 a prescription to go in.

2 THE CHAIRMAN: Is that
3 because it can be used for a non-medical
4 purpose?

5 THE PUBLIC: Medical use
6 or anything. Your leg, your arm.

7 THE CHAIRMAN: Do you think
8 that any substance that could possibly be used
9 for non-medical purposes should be -- for
10 example, like shaving lotion. --- ?

11 THE PUBLIC: It is used.

12 THE CHAIRMAN: Do you think
13 that should be on prescription?

14 THE PUBLIC: Well, no, not
15 really, no. He could shave, and he could go in
16 after all, he is not stupid or anything. He
17 could go in and get it at Eaton's or Zellers and
18 he could buy it, right? But that is not used
19 for that.

20 THE CHAIRMAN: It is not
21 used for what?

22 THE PUBLIC: Just what you
23 said.

24 THE CHAIRMAN: Not used for
25 shaving?

26 THE PUBLIC: You can drink
27 it if you want to drink it, as far as that goes.

28 THE CHAIRMAN: I see. It
29 is not used for drinking.

30 THE PUBLIC: No, it could be

1 used though.

2 THE CHAIRMAN: I was just
3 putting up a hypothetical question.

4 THE PUBLIC: No, I understand
5 you.

6 THE CHAIRMAN: So your
7 recommendation is that rubbing alcohol should
8 only be available on prescription?

9 THE PUBLIC: Right.

10 THE CHAIRMAN: Right.

11 Thank you very much.

12 THE PUBLIC: Thank you very
13 much.

14 THE CHAIRMAN: Dr. Killorn?

15 Excuse me, Professor Bertrand?

16 PROFESSOR BERTRAND: Yes.

17 Dr. Killorn, since you have been concerned with
18 the sedatives, could you help us understand how
19 it is the abuse of sedatives which is found to
20 be responsible for a growing number of deaths
21 actually, this is a fact, do not bring out the
22 amount of concern which would be proportionate
23 to the gravity of the possible effects of using ---

24 DR. KILLORN: That is actually
25 why I wanted to appear here today; to bring out
26 the point that I think this is a far larger
27 problem on Prince Edward Island than marijuana.
28 And not only in adults, but also in the young.
29 These drugs are available to high school students
30 and they are taking them.

1 PROFESSOR BERTRAND: The
2 point is, how is it that, we certainly know and
3 we have seen figures in this Commission showing
4 what you just said, there are deaths attri-
5 butable to that, to a great amount of sedatives
6 taking. How is it we are not concerned with
7 that? Can you explain that? What are the
8 motivations of the persons who use the
9 sedatives, who abuse them?

10 DR. KILLORN: What is the
11 motivation?

12 PROFESSOR BERTRAND: Yes.

13 DR. KILLORN: I think it
14 has perhaps something to do with what you said
15 this morning about what did somebody think about
16 the relaxing property of marijuana. I believe
17 that people are dealing with their problems by
18 chemical means. And what chemical means they
19 use depends on what habit pattern they develop.

20 PROFESSOR BERTRAND: Do you
21 have any figures showing the amount of sedatives
22 that could be sold, let's say, in Prince Edward
23 Island, actually? Do you have any idea?

24 DR. KILLORN: No, I don't
25 really have any idea, but I know the sale of
26 tranquilizing drugs had outstripped the sale of
27 alcohol in the United States in 1968.

28 THE CHAIRMAN: Where do
29 you get those figures, Dr. Killorn?

30 DR. KILLORN: Pardon me?

1 THE CHAIRMAN: What is
2 the source of that?

3 DR. KILLORN: Dr. Smith at
4 Guest House in Detroit, Michigan.

5 DR. LEHMANN: Dr. Killorn,
6 you mentioned that these drugs, and I gather
7 this comprises all minor sedatives, minor
8 tranquilizers and sedatives, these drugs are
9 lethal and there are many suicides committed
10 with some of them. Do you know if any suicide
11 was with piloryde?

12 DR. KILLORN: Not always,
13 because I know if it is a sedative, ^{if} there is
14 a sufficient amount taken either with or without
15 alcohol would cause death. I don't know if it
16 has occurred.

17 DR. LEHMANN: No, it has
18 never been recorded, but many, many attempts
19 with very large amounts have been made. You
20 also imply that all these drugs are addictive,
21 and like alcohol, physically addictive. Are you
22 aware of the fact that it has been shown both in
23 animal and human experience that "tiger mate" ,
24 a minor tranquilizer, cannot produce any physical
25 addiction either in dogs or other animals, or
26 in man, because it has a short-harm lifetime.

27 DR. KILLORN: I don't believe
28 that, even if it has been shown. I think anybody
29 can become addicted. I can take anybody in
30 this room and addict them to alcohol. It is not

1 addiction, I don't think, that this is actually
2 what I am speaking about. If I give everybody
3 in this room enough alcohol over a long enough
4 period of time I can cause him to have delirium
5 tremens.. Addiction and compulsion is what
6 makes it a disease, and I think there are two
7 components to this disorder. There are some
8 biochemical deficits, but I am sure whoever
9 was doing the experiments with minor tranquilizers
10 has not been able to find any more than those
11 at the present time experimenting with alcohol
12 that have been able to find. But they know
13 that it is there in some anatomic system in
14 the central nervous system, but there is a
15 definite psychological vulnerability which has
16 to be present also, and I think that these are
17 the people that we are speaking of.

18 There are a certain number
19 of people who can drink a certain amount of
20 alcohol, and one out of fifteen of them will
21 become a victim of the disease of alcoholism.

22 DR. LEHMANN: Alcoholism, it
23 is well known.

24 DR. KILLORN; But when we
25 are talking about these other drugs that act
26 just the same on the central nervous system,
27 the withdrawal state is just the same. It would
28 seem inconceivable to me that they are not going
29 to do something to the central nervous system
30 comparable to alcohol.

1 DR. LEHMANN: Some of the
2 central nervous system effects, yes, but they
3 do not produce withdrawal symptoms because no
4 physical addiction, particularly the tibernate
5 so far---

6 DR. KILLORN: I'm sorry, what
7 is the trade name for that.

8 DR. LEHMANN: I'm not sure, Warner
9 makes it anyway. Anyway, it is tibermate and
10 well, the important thing is, it has been
11 impossible to produce physical addiction and this
12 is explained by the fact probably that the health
13 life time in the organism is very short so it
14 cannot quite build up to the peak that's sufficient
15 to accumulate to produce physical addition.

16 DR. KILLORN: The harm lifetime
17 of alcohol in the system is not too long either.

18 DR. LEHMANN: But is is much
19 longer, and physical addiction to alcoholism, of
20 course, is well known for many years now.

21 I was just wondering about the
22 treatment of acute alcohol withdrawal symptoms.
23 Would you then feel that the general and almost
24 unanimous textbook recommendations, and that of
25 most physicians, that treatment of alcohol
26 withdrawal, mainly, that to give minor or major
27 tranquilizers to these people during the withdrawal
28 state is ill-advised.

29 DR. KILLORAN: Well, not major
30

the pill

he is getting from much more than the injection.

DR. LEHMANN: After the

acute withdrawal symptoms are over, the patient

who is an alcoholic is extremely anxious, and may be

liable to a relapse or to go back to alcohol,

you would feel he should not be given any

sedative, under any condition under medical

supervision unless it is given by injection?

DR. KILLORN: I would say

it should be given under strict supervision and

in a controlled environment until he didn't

require any more.

DR. LEHMANN: Well, he can't

very well stay in the hospital for four or

five months.

DR. KILLORN: I don't believe

he needs something for four or five months.

DR. LEHMANN: He would not?

DR. KILLORN: He may think

that he does because obviously he has been

sedating himself for years with alcohol. The

obviously feels that he does need some sedation.

The thing to do is try to convince him that

he doesn't.

DR. LEHMANN: I am not

referring to the patient, I am referring to

the many physicians who feel that something

should be done. Unless the patient can be seen

in psychotherapy an hour or two every day, he

should not be left with his anxieties because

1 he might then go back to alcohol. So many
2 physicians, in fact, the prevailing opinion
3 is now that if the physician feels that minor
4 sedatives or tranquilizers are indicated, they
5 should be given. But you feel that this is
6 wrong?

7 DR. KILLORN: Yes, I know.

8 DR. LEHMANN: The Alcoholics
9 Anonymous have presented a brief to us in which
10 they complained much the same as you do and
11 pointed out that under no conditions should
12 alcoholics be ever given any sedatives, medi-
13 cally or otherwise, and afterwards in the
14 discussion they changed their opinion somewhat.
15 They said, "Well, in these very severe cases,
16 and if everything else has failed, obviously
17 the medical opinion must have the last word."
18 But your medical opinion would be different,
19 then, from that of most of your colleagues?

20 DR. KILLORN: I don't think
21 that what you stated previously, that the
22 major tranquilizers are dangerous in the acute
23 withdrawal period--I would agree with this --
24 but after this period of time they are not
25 dangerous, and I think that material such as
26 mirium, spirium, trillifon, etc., if the
27 person is -- you can't have him going around
28 completely agitated all the time, and we can't
29 have him in psychotherapy every day. This is
30 impossible because there just aren't enough

1 people to go around to do this. I would say
2 that he could be on controlled medication as
3 long as it was controlled.

4 DR. LEHMANN: Major
5 tranquilizers, afterwards?

6 DR. KILLORN: I would agree,
7 yes, that is what I meant. I would not use
8 them originally because of the dangers, but I
9 would use them later if necessary.

10 DR. LEHMANN: Yes, that has
11 been pointed out and may well be one way of
12 getting around the dangers.

13 Now, specifically, with
14 reference to your suggestions, and that is,
15 of course, something of a problem that has
16 concerned the Commission a great deal, how to
17 avoid the unauthorized obtaining of sedatives
18 through prescription shopping. You propose a
19 system here which might be objected to, it seems
20 to me, on the basis of interferences with civil
21 liberties.

22 There would be a list of
23 people suffering from sedativism, addiction prone
24 people, and this may involve 5% to 10% of the
25 population, and there would be then lists
26 available to the government and the pharmacists
27 and physicians, and one could also ask why these
28 lists should not be given, for instance, to the
29 authorities which control the sale of liquor.

30 Wouldn't it be better to

1 simply say, "Well, these people are not going
2 to be sold liquor, if they are to be discriminated
3 against".

4 DR. KILLORN: Yes. I think
5 that is a good idea. You know, I think this is
6 a slow suicide. If the government is supposed
7 to be for all the people, I think a person has
8 a right to be controlled against his will. Yes.

9 In other words, if he is
10 going to commit suicide, then why not just let
11 him go ahead and do it. Why is there some
12 sort of major endeavour to try and stop this.
13 So this is the same thing to me.

14 Sure, I would put the same
15 restriction of alcohol on these people also.

16 DR. LEHMANN: Do you think
17 the number of suicides would decrease if people
18 could not use overdose sedatives?

19 DR. KILLORN: Well, the
20 suicide rates, and alcoholics and sedativists
21 are greater than the normal level -- perhaps
22 it may get higher, but I don't think it would
23 if you cut these things off.

24 DR. LEHMANN: Would it
25 necessarily become lower though?

26 DR. KILLORN: I think it
27 would if the materials are not available.
28 Perhaps they would find some other way, but
29 maybe they would find in the meantime some way
30 of relieving the tension, which is what we hope

1 for, and some way of living in society without
2 chemicals to relieve their condition, which has
3 been mentioned several times today.

4 DR. LEHMANN: But more
5 specifically, we very often have references to
6 the many fatalities reported with drugs such
7 as barbiturates or meprobamate , and so on.

8 So, I am just wondering whether
9 you feel if these drugs would not be available at
10 all, whether the suicide rate would go down, or
11 what you would think about the argument that if
12 people want to commit suicide and they can't
13 get a certain drug to do it, they would do it
14 with another drug or with an automobile, or with
15 a piece of rope?

16 DR. KILLORN: Well, they
17 may, but at least I think (portion inaudible).

18 DR. LEHMANN: If they don't
19 have sedatives therefore, they could commit
20 suicide earlier.

21 DR. KILLORN: I'm not sure
22 of this. I think there are other people here
23 who know more about it than I do, but I think
24 more people commit suicide when they are depressed
25 than when they are tense, and they are definitely
26 depressed when they are taking these drugs. And
27 most of them commit suicide while under the
28 influence of these drugs.

29 DR. LEHMANN: Now, if one
30 could obtain control of the issuing of prescriptions

1 would you think registration of every
2 prescription in a more exhausting way, as
3 it is done now, may be better rather than
4 anything short of having a list of people?

5 I am just wondering whether
6 you could conceive of a way in which the laws
7 could exist that no pharmacist is supposed to
8 give a patient these drugs that are ^{under}/prescription
9 and no patient is supposed to obtain prescriptions
10 without having told the physician that he already
11 had one. Can you conceive of any other way
12 of possibly enforcing this regulation without
13 having to resort to black lists of people?

14 DR. KILLORN: There may be
15 another way, I don't know. But when I call a
16 pharmacy about a person whom I go to see, and
17 they are heavily sedated, shall we say, almost
18 unconscious, and something has happened; either
19 they fall down stairs or hurt themselves in
20 some way, I know this person is suffering from
21 this disorder. I call the drug store and ask
22 them something about it, and many times the
23 answer I get is they fill the prescriptions
24 which are brought to them, and that if I wish
25 anything done about this, I should call the
26 federal authorities in Ottawa and have them
27 give a directive to the druggist that these
28 people are not to obtain any more drugs.

29 This is quite a lengthy
30 procedure for me to go through so I don't bother

1 doing it. So, I just don't give them any more
2 drugs, but somebody else does.

3 PROFESSOR BERTRAND: Yes, in
4 trying to understand why these sedative abusers
5 are not detected or do not carry out the same
6 amount of visibility and concern in a population,
7 perhaps you could help me understand this by
8 telling me what, in your experience, are the
9 characteristics of the heavy sedative users.
10 What group age do they belong to, in your ex-
11 perience, what social class do they belong to,
12 what do you know about them, who are they?

13 DR. KILLORN: I think they
14 are all classes, all groups, male, female; all
15 religions. I don't think there is any difference
16 between them and alcoholics, really, because
17 they are in the same group. It doesn't make any
18 particular difference.

19 PROFESSOR BERTRAND: When it
20 is linked to alcoholism?

21 DR. KILLORN: Yes. I think
22 it is.

23 MR. CAMPBELL: Dr. Killorn,
24 two hypotheses have been suggested to us about
25 the epidemiology of heavy use of these drugs.
26 It has been suggested on the one hand, that you
27 have alcohol readily available in the society;
28 you allow another drug, or another drug, in fact,
29 comes into widespread popular use, and
30 you have a population one way or another dependent

1 on alcohol. It is then suggested that we
2 would superimpose upon that another population
3 depending on some other drug. This has been
4 one hypothesis.

5 The other hypothesis would
6 be that you have this population dependent on
7 alcohol here, and the introduction of another
8 drug would cut into that dependent population,
9 given enough time for this sort of phenomenon
10 to occur, but it would cut into it rather than
11 being superimposed upon it.

12 Have you any view on which
13 of these two hypotheses would be more likely to
14 be correct?

15 DR. KILLORN: I think this
16 depends on the young, basically. It depends on
17 the habit pattern that the person forms in which
18 to relieve his chronic tension or anxiety, and
19 we are all tense today in this society, let's
20 face it, and the young are probably tenser than
21 adults in some ways.

22 Now, it depends, if a habit
23 pattern is developed, I think, in adolescence
24 and early adulthood, / ^{whether} it is going to occur
25 in this area. I think the Chairman mentioned
26 that it was said all over the country that alcohol
27 was the widest used drug in high school, etc.,
28 and I would agree with this, and that, therefore,
29 the rate of alcohol problems or dependency is
30 going to remain about the same.

1 If you, however, make this
2 other drug available on which people would
3 become dependent for relaxation, etc., a certain
4 number will become dependent on it probably,
5 rather than on alcohol, and this may, in the
6 foreseeable future cut into the level of the
7 amount -- the numbers of alcohol addicts and
8 make marijuana addicts, as you will. So, I think
9 it would basically cut in rather than superimpose,
10 in time. At the moment, I would say it would
11 just create another level.

12 MR. CAMPBELL: I was thinking
13 mainly of the present adolescent population there.

14 DR. KILLORN: Well, we cer-
15 tainly see alcoholics appearing at age nineteen
16 and twenty.

17 MR. CAMPBELL: Yes, and less.

18 DR. KILLORN: Yes, and less.

19 THE CHAIRMAN: Dr. Killorn,
20 what do you know about the non-medical sources
21 of these compounds to which you make reference
22 at the bottom of page five and top of page six
23 of the brief, where you call for more federal
24 consistence and prosecution on the non-medical
25 sources of these compounds? I would appreciate
26 any light you could throw on that. What do you
27 know of them?

28 DR. KILLORN: In the local
29 area is the only thing I know anything about,
30 though I have read about others, but I tried

1 mainly to confine this to the local area that
2 I figure I know something about. I think they
3 are available in the same area that illegal
4 alcohol is available.

5 THE CHAIRMAN: What I meant
6 to say/^{was,} what do you understand by the non-medical
7 sources of them? Do you mean illicit manufacture?

8
9 DR. KILLORN: No, I believe
10 that there are people who have these prescriptions
11 go around the same way and get several prescriptions
12 of these drugs but they don't actually take
13 them themselves, but they then take them to some
14 illegal alcohol outlet and then sell them to
15 individuals for alcohol, and now these are now
16 available in this area for other people who come
17 in to get them. I am sure they are available
18 in the same area, that's where they are.

19 THE CHAIRMAN: Thank you.

20 Dean Campbell?

21 MR. CAMPBELL: Assuming,
22 Dr. Killorn, that there is a perhaps, almost
23 somewhat fixed proportion of any generation that
24 have a tendency to drugs. Now, there is quite
25 a wide array of drugs available that a person
26 can become dependent on and these drugs have
27 consequences beyond the primary source of the
28 dependency.

29 I suppose the other con-
30 sequences are of importance in the framing of

1 social policy. Have you any feelings about,
2 let's say, an individual is in front of you
3 and somehow you have to make the choice, that
4 this individual would become dependent on that
5 drug or this one or this. Now, I am assuming
6 here that you can't prevent the dependency to
7 some drug occurring. Now, can you rank the
8 common available drugs in an order of social
9 and individual danger that results from the
10 dependency of it?

11 DR. KILLORN: That is a very
12 heavy question.

13 MR. CAMPBELL: It is a rather
14 important one.

15 DR. KILLORN: Yes, I gather
16 so.

17 Granted, I know very little
18 about cannabis and marijuana, really, personally,
19 and I don't know how much dependency develops
20 to this or how many people get in major difficulties
21 because of it, what percentage, although we have
22 heard a good deal about the dangers of overdosage.
23 So, the only two areas really that I can confine
24 myself to are alcohol and these sedative drugs.
25 And if you want me to make a comparison of which
26 one I would rather see someone dependent on, I
27 would say alcohol.

28 THE CHAIRMAN: Why?

29 DR. KILLORN: I think from
30 the effects that I have seen of them, of people

1 attempting to withdraw from them, I am sure
2 that in spite of the popular notion, that the
3 withdrawal from addiction to these drugs is
4 far greater than the withdrawal--for example,
5 -- heroin addicts which we see on film and
6 read in books, that the withdrawal takes a
7 prolonged period of time; that six weeks after
8 ingestion of the last dose of these drugs,
9 people are still having symptoms of withdrawal.

10 I heard an individual in
11 Winnipeg last June say, apropos to what the
12 Professor/^{there}was asking me previously about
13 substitution of librium, I believe it was,
14 in the alcoholic, he said that he didn't mind
15 this person becoming addicted to librium because
16 he felt that he could get along socially with
17 this and he would be able to withdraw from this
18 in anywhere from twelve to eighteen months.

19 And I don't think it takes
20 this long to withdraw a person from alcohol.

21 There is something about the
22 ingestion of pills and capsules which -- I heard
23 described by another person that a person who
24 is a drunk, if he is not really abusive, is
25 something like a wooly bear, or this sort of
26 thing, you know, frankly, so on and so forth.
27 Whereas if somebody is under the influence of
28 pills, it is something dirty like a slobbering
29 wolf. And if I had the choice, I would rather
30 have somebody addicted to alcohol.

1 DR. LEHMANN: Dr. Killorn,
2 I am sure you have seen many people who were
3 addicted, or are addicted to alcohol. How many
4 have you seen who are addicted to librium?

5 DR. KILLORN: I don't
6 think these figures ---

7 DR. LEHMANN: Probably not
8 as many.

9 DR. KILLORN: Not as many
10 because they haven't been around as long. But
11 it won't take too long.

12 THE CHAIRMAN: How many have
13 you seen addicted to them?

14 DR. KILLORN: How many have
15 I seen ---

16 THE CHAIRMAN: Excuse me,
17 I am told it is an unfair question, Doctor.

18 DR. KILLORN: That's all
19 right. I saw one man last night who was laid
20 out in my office. It happens every day. People
21 brought him in. This man, as you mentioned
22 previously, he had been a member of Alcoholics
23 Anonymous for about three years, and he hadn't
24 had a drink, and they brought him in and he was
25 just laid out. In fact, the girl in my office
26 said, "There is a fellow out there, drunk".
27 But he wasn't drunk. He was sedated so that he
28 appeared to be drunk. He couldn't stand and
29 the two gentlemen who were with him had to
30 assist him out because he couldn't walk. And

1 the innocuous drug that he was taking, I am
2 not sure what the trade name is, but it is
3 Fhaludar 300, which is a very innocuous type
4 of sleeping pill, supposedly.

5 DR. LEHMANN: It is not
6 supposed to be innocuous.

7 DR. KILLORN: Well, I thought
8 it was. Of course, I am still under the delusion,
9 and a lot of other people are, but this man
10 had started six weeks ago and I don't know how
11 many he was taking now, but he had a bottle of
12 about forty in his pocket.

13 DR. LEHMANN: It is like
14 barbiturates, one of the more dangerous ones.

15 Just to come back to librium,
16 because you mentioned this particular colleague
17 of yours, you said that he would rather replace
18 alcohol addiction with librium addiction and then
19 gradually withdraw the person from this more
20 manageable form of addiction.

21 I think you would find in the
22 literature that, while there are definite forms
23 of addiction to librium described, that the
24 behavioural deviations are not as dramatic and
25 as objectionable as the behavioural deviations
26 with alcoholism.

27 DR. KILLORN: That is probably
28 true, but it has just as much effect on the in-
29 dividual and his family and the people with whom
30 he comes in contact.

1 MR. CAMPBELL: Are you
2 seeing, Dr. Killorn, in your practice, and
3 in the Foundation, much by way of a problem
4 with the use of drugs that are available for
5 across the counter sale in the pharmacies,
6 but which do not require prescription?

7 DR. KILLORN: Yes, there
8 is some I think.

9 MR. CAMPBELL: Is this a
10 constant problem or is it an increasing problem?

11 DR. KILLORN: I don't think
12 it increases particularly. I don't know why.

13 MR. CAMPBELL: Is it a
14 significant problem?

15 DR. KILLORN: I don't believe
16 so, no.

17 THE CHAIRMAN: What are the
18 drugs that you put in this category, Dr. Killorn?

19 DR. KILLORN: Bromo Seltzer
20 Nytol, 222's. I don't know all the names, but
21 they are -- any of them that have sedatives in
22 them. It would be the same way, I think.

23 THE CHAIRMAN: Are there
24 any other questions or comments?

25 Thank you very much, Doctor,
26 for your assistance.

27 I call now upon Doctor Beck,
28 Mac Beck, Charlottetown Mental Health Clinic.

29 DR. BECK: Mr. Chairman,
30 I should first introduce myself and my colleague.

1 I don't know if the Mental Health Clinic is
2 an adequate description.

3 THE CHAIRMAN: Excuse me,
4 that is what I had here.

5 DR. BECK: I assumed that you
6 were reading from that.

7 My job is Director of Mental
8 Health within the province. I am here not as
9 Director of Mental Health, particularly, but as
10 Chairman of the Premier's Task Force on extended
11 care, and alcoholic treatment facilities in
12 Prince Edward Island, which rendered its report
13 in March, 1969.

14 With me I have Dr. John
15 Maloney, who is an obstetrician in the city,
16 Canadian Medical politician of some stature.

17 THE CHAIRMAN: Canadian
18 Medical ---

19 DR. BECK: Politician.

20 THE CHAIRMAN: That is a
21 powerful combination.

22 DR. BECK: He is Treasurer
23 of the C.M.A. at the present time. He was also
24 a member of the Task Force, and is here in that
25 capacity. I might add too, that he is a neophyte
26 provincial politician, having been offered for
27 nomination but not yet been nominated.

28 We, sir, have already presented
29 our brief, and with the consent of the staff of
30 your Commission, forwarded it to you some weeks

1 ago, the Task Force report. And we refer to
2 you, for your particular attention, the intro-
3 duction and the chapter dealing specifically
4 with alcoholism, Chapter 4.

5 We could also have flagged --
6 with my experience in commissions I know
7 how difficult it is to get some reading done,
8 the Appendix which also has to do with alcoholism.

9 We come before you and thank
10 you for the opportunity to make our presentation,
11 but we come here to speak only about the subject
12 of alcohol. That is our primary interest.

13 We hope that you have found
14 in the Task Force report some areas of departure
15 from common knowledge or concomitant approaches
16 to the treatment, rehabilitation and alleviation
17 of alcoholism. I don't think you would appreciate
18 it if we read all the chapters referred to.

19 I think we can really
20 summarize this to a much shorter form than you
21 now have it. I think it is very tightly written
22 and I don't know how we could improve on what
23 we have already tried to do in terms of brevity
24 or conciseness.

25 Perhaps in an attempt to
26 focus attention in certain areas, I could make
27 a few comments:

28 First, it appears to us that
29 the activities of this Commission as they have
30 been reflected in the newspaper accounts of its

1 hearing held across the country, reminds us
2 somewhat of a doctor who is energetically
3 treating his patient for a mole on the nose,
4 being unaware that the person is dying from
5 malignant carcinoma. All about us, and for
6 decades, and even now we have had the tragedy
7 of alcohol abuse rampant in our society.

8 The cost of this disorder which
9 involves lives lost, homes ruined, homeless
10 children, unincreased productivity, and the
11 increase of human misery, makes the use of all
12 the drugs in the society failingly insignificant
13 as compared to the misuse of the drug, alcohol.

14 In your report, or in the
15 report which you have, on page 43 and page 44,
16 you will find some statistics which we were
17 able to draw together on P.E.I., regarding the
18 prevalence of alcohol abuse. Statistics in this
19 field, as you know, sir, are notoriously difficult
20 to find. I think the basic problem towards this
21 is the fragmentation in our services; health,
22 education, welfare, medicine, social psychology,
23 alcoholism, and so on. There is no possible way
24 at the present time to get adequate statistics.

25 We have attempted to overcome
26 this in our study and that study is reported at
27 length in the Appendix.

28 But basically, the findings
29 come down to this: That during the two years,
30 1966 and 1967, 3862 different individuals appeared

1 in our courts, or other treatment facilities,
2 for the misuse of alcohol. This means that --
3 and this is one out of eight of all males
4 between six-^{teen} and sixty-five in Prince Edward
5 Island.

6 Of the foregoing 3862
7 persons, 1039 different individuals in these
8 two years can be classified as alcoholics either
9 because this diagnosis has been made at the
10 treatment facility, or because they had two or
11 more court convictions resulting from alcohol
12 related offences in any one of these years.

13 These 3,862 are,
14 granted, quite arbitrary, but if they are
15 arbitrary, they are on the conservative side.
16 Of the 3900 individuals so identified, only
17 68 were females. Studies done elsewhere indicate
18 that at least 20% of the adult population is
19 female and one can safely conclude that a lower
20 count on the female number of addicts represents
21 a dependence on court figures and that the overall
22 figure of 1039 alcoholics in Prince Edward Island
23 is therefore, too low.

24 MR. CAMPBELL: But you said
25 68; my copy says 6%.

26 DR. BECK: Oh yes, 6%. I
27 read the percent as an 8.

28 MR. CAMPBELL: Thank you.

29 DR. BECK: Elsewhere we point
30 out that these figures don't include those alcoholics

1 that either have got in touch with the law
2 or ended up basically, in this province, in
3 Riverside Mental Hospital.

4 We also note that in 1967
5 there were 2100 different individuals with five
6 or more jail sentences for the misuse of alcohol.
7 In effect, each one of these individuals spent
8 a hundred or more days during that year in jail.

9 These figures indicate the
10 prevalence and extent of this problem, and I
11 think the commonly quoted figure for other
12 individuals being directly effected by one
13 alcoholic individual is also a valid one. When
14 cut down to (3862) , it means somewhere between
15 3000 and 5000 Islanders by current count, are
16 now being negatively effected by this vast
17 problem. There is also no reason that we can
18 find, sir, to believe that the problem of
19 alcoholism on Prince Edward Island is one bit
20 worse or one bit better than anywhere else in the
21 country. If there are any indicators, it is that
22 our problem is somewhat less.

23 THE CHAIRMAN: Well, what do
24 you mean, then, by the statement that Prince
25 Edward Island has a high rate of alcoholism?
26 High by reference to what?

27 DR. BECK: High, period.

28 THE CHAIRMAN: That in your
29 opinion is an unacceptable rate, 1000 Islanders?

30 DR. BECK: 1000 people

1 is a lot of Islanders. That is high. It
2 demands a lot of effort on behalf of all towards
3 the prevention and amelioration, treatment and
4 rehabilitation of alcoholism.

5 Fifthly, we have noticed a
6 recurrent request at your hearings, and I noted
7 again in Moncton yesterday, for the establish-
8 ment of special referral centres for the treat-
9 ment of drug addiction. Your sanction of this
10 proposal we would consider to be a serious
11 mistake. There are many and diverse personal
12 problems among our citizenry. To list them
13 you could go on, alcoholism, drug addiction,
14 poverty, mental illness, retardation, school
15 drop-outs, personal problems, mental health
16 problems. All of these have one common point
17 and that is the person in need and the family
18 around them.

19 Now, I refer you, sir,
20 again to our discussion in the introduction
21 and the first chapter of the Task Force report,
22 to the concept that the service assistance for
23 these many and diverse problems should be
24 centralized in their operation and integrated
25 in their operation, rather than following the
26 tendency to set up separate disease entity
27 facilities. The establishment of organization
28 and facilities has, I think, been shown
29 to historically/be a step in the wrong direction,
30 that it fragments our professional and economic

1 resources.

2 THE CHAIRMAN: Would it
3 be convenient if we just pursued that for a
4 minute, here?

5 DR. BECK: I just have one
6 thing further left to say.

7 Finally, we would be dis-
8 mayed to find the limited amount of our economy
9 placed on the drug problem to the detriment of
10 the much greater problem of alcohol addiction.
11 And we have some fear of this because there
12 seems to be a symbolism, a concern throughout
13 the land, and this is being reflected in the
14 newspaper accounts of your hearings, at least
15 that the drug addiction problem is the big
16 problem.

17 THE CHAIRMAN: Well, first
18 of all, when you -- you contrast two things.
19 You refer to the alcohol problem and the drug
20 addiction problem. Do you not consider the
21 alcohol problem to be a drug addiction problem?

22 DR. MALONEY: Yes.

23 DR. BECK: Yes, I do. I see
24 no distinction.

25 THE CHAIRMAN: You see it
26 as part of what you refer to as the drug addiction
27 problem?

28 You would say it is part of
29 what is referred to as the drug addiction problem,
30 the alcohol problem?

1 DR. BECK: Yes, the alcohol
2 problem; really, these are all drugs.

3 THE CHAIRMAN: Well, this
4 is it. I must disclose our own assumption
5 that alcohol is one of the drugs that we are
6 required to look into.

7 DR. BECK: This certainly
8 hasn't been appearing in the newspaper accounts.

9 THE CHAIRMAN: Well, you
10 know ---

11 DR. BECK: I think the
12 thing to talk about today brings Dr. Killorn here
13 today to talk about the other non-medical drug
14 problem.

15 THE CHAIRMAN: I would like
16 to pursue just a bit this question of whether
17 we should -- you said it would be an error to
18 approve or to accept a proposal for special
19 referral centres for drug addiction.

20 Now, in order to pursue this,
21 I assume, like you apparently do, that these
22 proposals had in mind rather the other drugs,
23 chiefly newer or different drugs, and they weren't
24 contemplating alcohol, and I will assume that
25 for the purposes of the discussion. I am speaking
26 of proposals that were made, and proposals made
27 in Moncton yesterday. I would think that they
28 had in mind treatment for the
29 use of psychedelics and some of the other drugs,
30 amphetamines, speed, and so on.

1 DR. BECK: We are caught
2 sort of ---

3 THE CHAIRMAN: Yes.

4 This raises the question -- These
5 centres as they have been proposed to us, I think
6 are thought of as doing a number of things, I
7 mean conveying information, doing some referrals,
8 making some, perhaps, competent diagnoses. I mean,
9 they vary. It varies from one place to another
10 just what they contemplate.

11 But, do you think when one
12 comes to treatment in its most comprehensive
13 sense, that is, understanding what you are con-
14 fronting, diagnosing it and identifying it
15 properly, being aware of the properties of the
16 particular substances being used and being able
17 to make intelligent referral to the necessary
18 technical assistance as well as being able to
19 render a sort of consultive service, that is,
20 producing a proper psychological environment
21 while having these tests. Do you think that
22 that requires a degree of specialization?

23 DR. MALONEY: A degree of
24 specialization, true, but this doesn't mean
25 separate referral centres where you fragment
26 your professional resources.

27 THE CHAIRMAN: What would
28 be ---

29 DR. MALONEY: What is the
30 difference between a social worker working with

1 a tranquilizer addict or alcoholic addict,
2 or any other drug addict?

3 THE CHAIRMAN: Well, yes,
4 that raises the question of the extent to which
5 the experience of alcohol is applicable to
6 this other use of drugs.

7 DR. BECK: To expand
8 Dr. Maloney's point, the same personal, social
9 and family problems are found not only in the
10 alcoholic and in the drug addict, if you wish
11 to distinguish those two, but also in the
12 family whose home is in danger of breaking up,
13 and maybe involved in child welfare facilities
14 or the family with mental health problems. The
15 common denominator here is the person, not the
16 drug, and not the particular drug, whether that
17 is alcohol or cannabis.

18 PROFESSOR BERTRAND: Yet
19 would you say, Dr. Beck, that the professional
20 abilities that are either natural or developed
21 in the specialist who has to deal, say, with
22 a rebellious youth expressing its rebellion through
23 speed, are very similar to the abilities which
24 might be asked for a person who has to work with,
25 say, a group of alcoholics?

26 DR. BECK: On the basis of
27 my own experience, I can't see any essential
28 difference.

29 DR. LEHMANN: And the age
30 would not make any difference either, since

1 alcohol problems are usually about ten years
2 older at least than the other problems.

3 DR. BECK: No, I say that
4 as a child psychiatrist too.

5 DR. LEHMANN: I am beginning
6 to wonder whether the child psychiatrist thing
7 is a reasonable one too.

8 MR. STEIN: There is another
9 way of looking at this. It has been suggested --
10 at one time it was suggested to me actually,
11 we were talking about services to people who
12 were in Vancouver physically addicted to heroin,
13 that it was necessary to have a variety of --
14 let's call it environmental settings ranging from
15 something like cinenon , perhaps, and that
16 kind of environmental setting to a John Howard
17 Society, to a family service agency. In other
18 words, different people will find different kinds
19 of environments more conducive to enter into the
20 process of trying to deal with their own problems,
21 and that there was a danger in placing everything
22 under one centralized service.

23 Now, do you have any thoughts
24 along those lines? The point is, should there
25 be various ways of entering? Although, whether
26 or not your contention is correct, the general
27 phenomenon that you are dealing with is the same, that
28 there would still be various points of entry for
29 people when seeking help?

30 DR. BECK: May I make it clear

1 first that I am not talking about centralized
2 service, I am talking about de-centralized
3 ones, and when I am talking about de-centralized
4 I am talking about de-centralized to population
5 units of something like 25,000. I am not
6 talking about a Toronto Syndrome where you set
7 up a drug treatment facility which handles all
8 of Metropolitan Toronto, and this syndrome is
9 not confined to Toronto. It is present in
10 Alberta, it is present in Prince Edward Island.
11 But you try to deal with such a vast number of
12 people that the service can't effect -- deal
13 personally with none.

14 MR. STEIN: On that kind of
15 criteria, there is also suggestion that when
16 we go shopping, if I can put it that way, we
17 might go twenty miles out of our way if there
18 was a good buy for a used car in a car lot in
19 North Vancouver, even if we lived in Vancouver.

20 What I am trying to get at
21 is, I am wondering whether the geographical
22 factor plays a large role. It may play a large
23 role here in Charlottetown. Does it play a
24 large role, do you feel, in the way in which
25 people seek out services? Do they go in their
26 immediate geographical neighbourhood in a larger
27 urban centre?

28 DR. BECK: It plays a large
29 role in rendering the services inefficient and
30 ineffective, because what happens is, they shop;

1 they go twenty miles and they get the diagnosis,
2 and there is nobody then to render the long term
3 assistance that is necessary for these types
4 of problems. And these are personal, family
5 problems which require being looked after and
6
7 requiring intervention over a long period of
8 time.

9 It is really a
10 problem of delivering service rather than
11 delivering diagnosis.

12 MR. STEIN: I will try one
13 last point on this, at the risk of pounding
14 it to death.

15 DR. BECK: I wish you would
16 pound this one all day. There is nothing I
17 would rather talk about.

18 MR. STEIN: There is something
19 that has been of interest to me for a long time,
20 and that is what the nature is that motivates
21 people about what they want to do about their
22 own situation, and it has been my observation
23 that one cannot make simple generalizations
24 regarding this, about what anyone will decide
25 about when they are trying to^{do}/something about
26 the situation, and the variety of alternatives
27 in mood and texture and feeling and when environ-
28 ment was an important consideration, about
29 realizing what latent motivation one might have.

30 Maybe I am painting an image

1 in my mind of a kind of stereotype of these
2 de-centralized services. It would all have
3 very much the same tone.

4 DR. BECK: If we could
5 de-centralize our services like this, you are
6 going to develop a wide variety, but I think
7 more important -- perhaps a more practical
8 question than the one you asked about what is
9 it that motivates the patient to go, what we
10 have now is a virtually inaccessible system for
11 anybody, regardless of their problem.

12 I have experienced general
13 practitioners who have been here for years, phone
14 me up to say, "What do you do with an unwed
15 mother?" They just don't know the welfare system.

16 And ^{if} the experienced practi-
17 tioner doesn't know it, think of the poor client.

18 And our service delivery
19 systems are now set up so that the points of help
20 are not emotionally and geographically accessible.
21 And this is the kind of block that it takes a
22 lot of personal motivation to get beyond. It is
23 a real struggle to find out where to go to get
24 help with any kind of a problem, and what we are
25 proposing is a common point of reference for all
26 people with all kinds of problems, in the common
27 point of penetration, and that kind of penetration
28 in the home district.

29 DR. MALONEY: Mr. Chairman,
30 may I go back to a question that Dr. Bertrand

1 asked earlier on, which I thought was a rather
2 interesting one, as to why it was that people
3 generally were not concerned about the damage
4 to our society that alcoholism does, and seem
5 to have gotten wrought up about marijuana.

6 I think there is a very
7 definite answer to that, and that is as follows:
8 If you go back into the ^{Quarrels} of history
9 you go back and you find out the most interesting
10 things are not what the people thought about, but
11 what they had in common while they were fighting
12 about something else.

13 Now, similarly, the point is
14 that we are unconscious of our basic assumptions
15 until you move from that culture which has those
16 unconscious basic assumptions to another and see
17 other basic assumptions.

18 Now, if you, for instance,
19 were in Arabia, you would think about nothing
20 but the stink of camel's dung in a tent. You can
21 go through this -- for an Islander, for instance,
22 to go to Toronto, he knows that a Torontian thinks
23 that a slum is a fishing shack in Newfoundland
24 or an old farmhouse on Prince Edward Island.
25 When I walk down Bloor Street I am convinced that
26 the ultimate slum is Bloor Street because you
27 can't hear yourself talking. There is such a
28 terrible roar you can't sleep at night. You see,
29 there is a basic assumption here.

30 Now, we have all grown up in

1 a society, we inherited alcohol prehistorically,
2 and we grew up surrounded by the damage that
3 alcohol does to our society, and this is why
4 we are largely unconscious of it. It is because
5 you find here a new drug entering the scene
6 that you become conscious of possible damage
7 of that and take the other for granted.

8 It is similarly, thirty or
9 forty years ago in Scotland, if you walked the
10 street in Glasgow, every third person had a
11 scar on his neck from tuberculous pasteurellosis
12 because they didn't pasteurize their milk. And
13 you go through different countries where they
14 took certain abnormalities for granted. We are
15 in this same state with alcoholism.

16 I don't think that, for a
17 minute, in twenty-five years time we won't look
18 back on this and say how blind we were.

19 PROFESSOR BERTRAND: I think
20 I was hiding from myself my own assumptions.
21 My question really was this: is it because so
22 many of us in our social classes, all age groups,
23 you know, are touched by that problem? We would
24 have to make a real examination of our consciences,
25 that we don't want to really think of the damages
26 of alcohol and the sedatives. Where we have the
27 details, we really know that has occurred, whereas
28 with marijuana we don't know that that has occurred.

29 DR. MALONEY: Well, I don't
30 think that we as a society or a culture have ever

1 faced several basic questions on humanity
2 bluntly, and that is, does man need anything
3 other than to keep his back warm and to fill
4 his belly and to procreate his kind? Does he
5 need something else to make his life livable,
6 to offset the ordinary anguish and misery of
7 just every day living. And I think the history
8 of man shows that he does need something else.

9 Therefore, what you have to
10 work out is what you would call your "return risk
11 ratio". In other words, you have to get some-
12 thing which gives you a high return in making
13 life livable, and also, at the same time, gives
14 you a low damage/^{ratio} to the individual and society.

15 Now, so far we have done
16 this in various ways; we have certain things that
17 do it, music and pageantry, and many things that
18 will give you that return without much damage.
19 We have--our best one, so far, is alcohol, but it
20 gives you this escape. I don't think that it is
21 really correct to think about alcohol as a crutch
22 because for a great number of people it is a
23 very beneficent drug.

24 At the same time, because of
25 our number, say, 90% of the people find that it
26 does give them this, they should not be ashamed
27 to say that there are 5%, 10% or whatever you
28 want percent, of people to whom this does a great
29 deal of damage. What do you do when you have a
30 high -- a low benefit ratio? What you do is try

1 and get another means of getting the same thing
2 which makes life livable without the damage.

3 And when we are faced with
4 alcohol, for instance, the thing we need to do
5 is then study the problem of the people who are
6 not able to handle alcoholism. And when you
7 study any problem in our age, you go to the
8 scientific methodology and you take the money
9 resources and personnel, and you study how you
10 can identify those people who will become
11 alcoholics fast, or are becoming, and how can
12 you cure them. So you are faced with a straight
13 problem of dealing with these people who cannot
14 handle alcoholism and getting a substitute for
15 them.

16 DR. BECK: It is a straight
17 problem, but not a simple problem.

18 THE CHAIRMAN: I was going
19 to say, what have you found?

20 DR. MALONEY: We haven't
21 found anything yet, because we really haven't
22 begun to study. I was answering Dr. Bertrand's
23 question, and she was asking if we all feel a
24 little guilty about it, and I say, we all feel
25 guilty about it, but wrongly. We should be
26 proud to use alcohol because^{of} the good benefits
27 it gives you and we should be (unintelligible) to have
28 five or six percent of our population who are
29 unable to handle it, and we are not doing anything
30 about it.

1 PROFESSOR BERTRAND: Yes,
2 but perhaps when you say we should be proud, I
3 have the impression that you move from one order
4 of reasoning to another one. Imperically,
5 we have to recognize that there is a need for
6 some way of alleviating the tensions, but morally
7 we may not be that sure that we want -- this is
8 another matter, this is very difficult.

9 DR. MALONEY: This is one of
10 the questions that we have to face. Do we think
11 there is anything intrinsically wrong in using
12 substances that are mood-altering? Certainly, it
13 is just a matter of quantity, because we often
14 do it qualitatively. The very fact that we fix
15 a room that is pleasing, that we have colors
16 around us that are pleasing, we are pandering
17 to this in our lives and titillating ourselves,
18 and the whole history of art is that, isn't it?

19 We are doing that in the
20 foodstuffs with essences and sauces and so on.
21 All we have to do is do it with less damage to
22 society and the individual, so what we should do
23 is get about doing it.

24 THE CHAIRMAN: What do you
25 understand by damage to society?

26 DR. MALONEY: Well, damage
27 to society is what happens, for instance, to a
28 family with alcohol, and what happens to the
29 individual and society when you have a suicide
30 rate and low productivity, and all the things

1 that go with excess and abuse of drugs.

2 DR. BECK: Brain damage and
3 body damage.

4 THE CHAIRMAN: Would the
5 productivity be predicted by the damage?

6 DR. MALONEY: Yes, it is.

7 THE CHAIRMAN: Well, gentle-
8 men, I am wondering where we go from here with
9 this very carefully prepared brief, and I think
10 we have to read it carefully. It is certainly --
11 your submission to us, your recommendation to us,
12 considering the importance of comprehensive
13 approach in treatment in this whole area is very
14 important, and we will study that very carefully.

15 Is there anything else that
16 you feel in terms of priority, that you would like
17 to direct our attention to at this time, knowing
18 our area?

19 DR. BECK: Well, I cannot
20 emphasize too strongly how this approach has
21 its
made a wide spectrum of all/services, basically
22 non-healthy. And Marie Bertrand, sir, is on
23 the same commission as I am on in emotional
24 learning disorders in children, and I am sure
25 that she can talk to you at length about the
26 observations we have had on this level, on a
27 different, but not unrelated, problem.

28 The other thing, I think,
29 that would merit some of your attention, is to
30 look at the fragmentation that has happened

1 around the drug, alcohol,--the setting up of
2 alcohol facilities, and I am confident that
3 if you did some on-sight visits to various
4 alcoholism treatment facilities across the
5 country, you would find the ~~length~~ of the fact
6 of this fragmentation illustrated for you there.

7 Our group went to the
8 Toronto facilities, and saw it there. I was
9 not there myself, but they came back reporting
10 the same kind of thing.

11 This is a question which I
12 consider fundamentally important and the obvious
13 and superficial answer is to establish a drug
14 referral centre, and I submit to you, sir, that
15 that is no answer. And if you wish to look
16 into that point of inquiry, you can find it --
17 as a separate entity, and you will find it well
18 illustrated in the Alcoholism Foundation centre.

19 DR. LEHMANN: You would feel
20 there should be no Alcoholism Foundations?

21 DR. BECK: Ideally, no.

22 DR. LEHMANN: And what are
23 the negative effects that are observed then in
24 centres such as in Toronto, for instance? The
25 restricted nature of the treatment that was
26 offered to them?

27 DR. BECK: And the service
28 and the range of extent of services being offered.

29 The ability of the Alcoholism
30 Treatment Foundation to totally ignore the fact

1 that 70% of the jail population is alcoholic,
2 that is their most single vivid mistake. The
3 tendency of Alcoholism Foundation facilities
4 to become treatment facilities for the middle
5 class alcoholic. The lack of a spectrum of
6 services that we have outlined here in these
7 four phases to cover the total problem, from
8 acute de-toxicification to the chronic habitual
9 of the jail system, jail treatment system, I
10 must add, because this is the most important
11 single system our society has yet devised for
12 alcoholism.

13 I can go on and on with this
14 but I don't wish to impose on your time other
15 than to state that this is not a logical way to
16 attack a problem as widespread as the addiction
17 problem. It can't be handled that way.

18 THE CHAIRMAN: What about
19 this problem of credibility that we are always
20 being told about in various ways, that seems to
21 come up time and again in different contexts?
22 The credibility about the information provided,
23 the credibility of the people who provide treat-
24 ment, what do you think about that? I mean, to
25 be less than candid about the impressions we
26 have received across the country, and we didn't
27 mention the strong suggestion of dissatisfaction
28 with the institutions, the lack of confidence
29 in our whole institutional approach?

30 DR. BECK: I think the lack of

1 credibility is perfectly justified, and I
2 myself was horrified at what we saw, and the
3 other commissioners who went across the country.

4 My fear, as a professional,
5 is that the public doesn't catch up with us too
6 soon before we have a chance to straighten out
7 our help, because it is in terrible disarray, and
8 quite frankly, we are not providing treatment,
9 and this is especially true in the larger centres --
10 Montreal and Toronto.

11 What we are providing is
12 repetitive diagnosis. We are not providing a
13 service appropriate for the need, either for the
14 drug or the alcohol problem, or any other personal
15 problems that our citizens would face.

16 THE CHAIRMAN: Thank you.
17 Is there anything before we conclude this sub-
18 mission? What do you visualize to be the role
19 of the federal government in relation to your
20 submission? What do you think of the federal
21 government's view, particularly, because we are
22 appointed to make recommendations to the federal
23 government?

24 DR. MALONEY: Well, I don't
25 see how federal government can do much because
26 ultimately it comes down to the revenue coming
27 from liquor sales, and this is provincial.

28 The only thing the federal
29 government could do is to set some standards
30 of research and treatment for a province and hope

1 that the province would take it up.

2 DR. BECK: I would add to
3 that that one important thing that the federal
4 government could do is to exercise some controls
5 over money and expense in that through the
6 provision of rational controls it can start to
7 modify the local application.

8 Now, what has happened so
9 much in the past is that the controls haven't
10 been rational and this involves a whole process
11 of government changes and attitude.

12 But, basically, for the
13 governments to accept the proposition, both
14 federal and provincial, that while they fund a
15 service they don't necessarily operate that
16 service. And this is a continuing malaise in
17 the government, that they feel that the only way
18 they can hold this service is to operate it
19 themselves, and in fact, when they start doing
20 that, then controls break down because there is
21 no balance of forces.

22 So, I would say to your
23 question; one, that the federal government has
24 the responsibility to see that there are reasonable
25 and rational controls on the money it expends.

26 Secondly, the federal govern-
27 ment has a very big role in the establishment of
28 an information centre, in the establishment and
29 promotion of research. And I don't know -- I am
30 sure Dr. Lehmann knows much more about this than I,

1 I see a role for the Canadian federal govern-
2 ment getting into somewhat the same type of
3 operation as the N.I.M.H. has in the States.
4 I don't know if you would like to speak about
5 that, Dr. Lehmann?

6 DR. LEHMANN: It would
7 certainly be desirable. For instance, the
8 Research Medical Council, which is a federal
9 council, could be practical, but it is mainly
10 a matter of funding. That could be built up
11 to the level. Certainly everybody would benefit
12 from it.

13 Since I am talking now, I
14 am wondering if I might ask you one question
15 with regard to what you propose. Would you say
16 that the emphasis you put on the de-centralization
17 of treatment services for mental health casualties,
18 including drug takers and drug addiction,
19 alcoholism and so on, that this would be in line
20 with the general tendency, or general lines of
21 development of modern psychiatry or modern
22 medicine in general, that in medicine in general
23 there is this tendency to de-centralize the
24 community centre or community base?

25 DR. BECK: Yes, very much so.
26 And I believe perhaps the best example we have
27 of this principle in operation, although the
28 regions are yet too large, is the sectorization
29 system in Montreal of psychiatric services.

30 I think this is one of the

1 things that made it possible for the commission
2 to start with the other commission, to start
3 thinking in the terms it did, and I can't
4 pretend for a minute that some of the Canadian
5 commissions' thinking isn't reflected in this
6 Task Force.

7 THE CHAIRMAN: Thank you
8 very much gentlemen, for your help.

9 We call now on Dr. Wolf Leon.
10 Perhaps I will let you
11 identify your capacity, Dr. Leon.

12 DR. LEON: I come as a
13 private citizen mostly, and a psychiatrist in
14 the employ of the provincial government, and I
15 work mostly at the Institution at Riverside
16 Hospital. Some of my time is spent at the out-
17 patient services.

18 In preparing this statement
19 I was talking to Mr. Jack Nicholson, who is
20 Crown Prosecutor, and who has actually defended
21 a number of people in trials in this province
22 involving drug trafficking.

23 To the public it seems
24 incongruous to be told that marijuana is relatively
25 harmless, and yet the penalties for possession
26 are similar to penalties for heroin. Likewise,
27 all are aware that the addict is sick and yet
28 he is treated as a criminal. Similarly, marijuana is
29 supposedly harmless for the user smoking ^{two or} three
30 cigarettes a week, and yet emergency medical

1 services are seeing increasing numbers of
2 patients in panic states and delirious states
3 from drugs which include marijuana. It is
4 stated that drugs are out of control and we
5 are in a state of crisis.

6 Our own experience on the
7 Island, with alcohol and sedative drugs leads
8 us to suspect any sedative or euphorogenic
9 drug if made freely available will be abused by
10 a sizeable portion of the population. They will
11 display increasing heavy use, chronic intoxication,
12 and its accompanying hazards of poor
13 controls and poor judgment. If society is
14 allowed the privilege of the free or uncontrolled
15 use of a drug or chemical, for example, alcohol,
16 it will be at a price to society and that price
17 will be extorted from the young. It should be
18 possible to estimate the price before society
19 thinks of accepting any drug for even controlled
20 use.

21 No society seems willing to
22 pay the price associated with heroin use; New
23 York has about four hundred deaths per year
24 and Persia reports it is executing its traffickers.

25 LSD has been revealed as
26 leading to psychosis and borderline schizophrenia
27 and no one would recommend that it be free of
28 legislative control. Its main source seems to
29 be illicit manufacturers and probably they should
30 be prosecuted like drug traffickers.

1 Amphetamines, the main source
2 of which are legitimate manufacturers, is regarded
3 as second to heroin in danger to the individual.
4 No one suggests they should be removed from
5 control. "Speed kills" probably was coined by
6 the amphetamine addict himself, as he sought
7 still greater euphoria but yet it does not stop
8 him using it.

9 Nobody would recommend the
10 sedatives under the Food and Drug Act should be
11 made any more available; in fact greater control
12 by the authorities needs to be exercised through
13 the different professional bodies which use these
14 drugs.

15 This leaves marijuana. If
16 one accepts as true that mild use of marijuana,
17 which might be described as one or two cigarettes
18 in an evening or a weekend which leads to mild
19 intoxication, and no dependence, how then does
20 one explain the increasing use by people of
21 heavier and heavier doses of marijuana, of hashish
22 and the associated use of marijuana and ampheta-
23 mines?

24 There appears to be some
25 argument that marijuana does not lead to heroin
26 addiction but there is no doubt that marijuana
27 use is often associated with amphetamines in
28 conjunction with the marijuana. The users in-
29 vestigated in the LaGuardia Commission some years
30 ago smoked six to ten cigarettes a day, the users

1 of hashish investigated in the East use two
2 to six grams of hashish equivalent to twenty
3 to sixty cigarettes a day. On an open line
4 program the other night which I was listening
5 to, one person phoned from Vancouver recom-
6 mending the legalization of marijuana and
7 claimed there were no ill effects from mari-
8 juana. He then described a visit to Mexico
9 where he had free access to the drug and the
10 group who were with him were constantly stoned
11 and intoxicated and said nothing other than
12 this is great, this is groovy.

13 All this suggests to us
14 that in susceptible people, and that may mean
15 any or all of us, that increased availability
16 means increasingly heavy use. Heavy use is
17 certainly associated with adverse effects
18 and (McLaughlin) refers to the amotivational
19 syndrome characterized by passivity and non-
20 productiveness.

21 Until more is known about
22 marijuana, my position as a parent and psychia-
23 trist is quite clear - I would not like to see
24 marijuana legalized. Until more is known of
25 this drug it is morally indefensible for
26 society to make this drug even as free as
27 alcohol.

28 I would like to see a
29 change in the law; a Marijuana Control Law
30 which would define trafficking.

There should be no trafficking without sale. I would also like to see possession of marijuana treated as a summary conviction rather than an indictable offence.

I cannot see that the having or not having a criminal record as any argument for the legalization of marijuana. Apart from immigration and the Federal Civil Service, nobody else has access to the fingerprint records. Too much has been made of this as an argument, as if Canada was a police state and everybody had access to police records.

THE CHAIRMAN: Thank you, Doctor.

I don't understand. Did you say that was jointly prepared?

DR. LEON: I beg your pardon.

THE CHAIRMAN: Did you say that brief was jointly prepared by you and Mr. Nicholson?

DR. LEON: Yes.

THE CHAIRMAN: Crown Prosecutor?

DR. LEON: Yes.

THE CHAIRMAN: What is your relationship to the legal aspects of this subject: You are a physician, are you?

DR. LEON: Yes.

THE CHAIRMAN: A psychiatrist. What professional contact have

1 you had with drug use?

2 DR. LEON: Nearly nil on the
3 Island, if you are talking about marijuana and
4 amphetamines.

5 THE CHAIRMAN: What exceptions
6 are you making there? What drugs have you had
7 contact with?

8 DR. LEON: Loads of alcohol,
9 loads of sedative drugs.

10 THE CHAIRMAN: Have you had
11 any opportunity to observe any -- at any time, any
12 of the users of any other drugs, any of those
13 who become involved with the law?

14 DR. LEON: Could you ---

15 THE CHAIRMAN: Have you had
16 an opportunity at any time to observe the users
17 of any other drugs, particularly those that have
18 become involved ^{with} / the law in your capacity as a
19 psychiatrist?

20 DR. LEON: Not to any extent.

21 THE CHAIRMAN: Why are you
22 associated in a brief with Mr. Nicholson as Crown
23 Prosecutor.

24 DR. LEON: I was asked to
25 serve on a panel some time ago about drugs, and
26 the issue seemed to be not how one educates the
27 public, but more whether we should legalize --
28 or whether the sale of marijuana should be an
29 offence or not. And I discussed -- and I felt
30 this was basically the issue, rather than the

1 legalization of
2 debates on/marijuana at all. In making this
3 brief I thought there should be some representa-
4 tion. I thought one can't look at marijuana
5 without addressing oneself to the basic argument,
6 which I feel anyway, is the basic argument,
7 whether you get punishment and what punishment
8 you have, and what will be the penalties to a
9 person who was caught in possession of marijuana.

10 I felt this seems to be the
11 thing that most people are interested in.

12 THE CHAIRMAN: What are your
13 conclusions on that?

14 DR. LEON: Whether one should
15 be ---

16 THE CHAIRMAN: What are your
17 conclusions on that point, the penalties?

18 DR. LEON: The penalties.
19 I would have to speak again as a private in-
20 dividual because I don't know too much about law
21 or anything else constitutionally.

22 THE CHAIRMAN: I take it the
23 statements you make about the drug are not made
24 in a professional capacity. You are not making
25 them as a psychiatrist.

26 DR. LEON: No.

27 THE CHAIRMAN: What are your
28 opinions on the penalties as a private citizen?

29 DR. LEON: As a private
30 citizen, I would feel if you are going to have
prohibition of the use of it, and it remains a

1 federal statute, and the control remains in
2 the federal government, then you are going to
3 have some penalty, and this probably should be
4 a fine of -- and this would be for the first
5 offence. I think that this kind of practice would
6 suggest society is not condoning the use of
7 this drug.

8 And you run into all sorts
9 of things about how many times people are using
10 it and the condition of the person themselves.
11 Then you have other matters to look at.

12 MR. STEIN: Yes, you said,
13 if I heard you correctly, that the only effect
14 of a criminal record that you could think of was
15 the Federal Civil Service and the question of
16 immigration; is that right? It has been pointed
17 out to us that there is also a problem in terms
18 of certain professions such as the legal pro-
19 fession, which is a private matter, that there
20 is a possibility, a very definite possibility of
21 being barred from entry into professions with a
22 criminal record.

23 And also, the question of
24 obtaining employment or bonding. It has been
25 suggested, and I am aware of this from my own
26 work in this field, that this is also a factor.
27 Are you in disagreement with those kinds of ---

28 DR. LEON: I am sure there
29 are a lot of people who have broken the Criminal
30 Code of Canada and have a criminal record. I don't think

1 it would stop you from getting into universities,
2 as I have heard on panels. I don't think it will
3 stop you entering medicine if you have a crime
4 against you for the possession of marijuana, and
5 I don't think it will stop your entering into
6 the legal profession. And that is my understand-
7 ing of it.

8 I think it potentially could --
9 and when you compare a thing which is a potential
10 hazard to an actual hazard, and I raised this
11 factor with Dr. Unwin because he made this point,
12 and he agreed with me and he said the only point
13 that he could see is that you wouldn't get into
14 the States, if you wanted to emigrate to the States.

15 THE CHAIRMAN: Are there any
16 other questions?

17 THE PUBLIC: You mentioned
18 the relationship between amphetamines and
19 marijuana use. I wonder if you could elaborate
20 on this a bit more and perhaps give me the source
21 of this information and whether or not people
22 who usually take amphetamines usually take
23 marijuana, or whether it is marijuana people
24 who might go on to take amphetamines?

25 DR. LEON: My own experience
26 of people who are taking -- heavy use, or are
27 you going to call it abuse of drugs? Then you
28 get into this argument, are you going to have
29 users of drugs and abusers of drugs. From my
30 own experience, people who are using drugs heavier,

1 will then use heavier doses of marijuana.
2 This is in the literature. Then many of them
3 will use amphetamines. Many people might
4 start on amphetamines first. I don't think
5 this solidarity has been surveyed too well.
6 But there is no doubt about a heavy use of
7 amphetamines among marijuana users, and that
8 even the doctors who see these patients in the
9 out-patients at Montreal and Toronto, they
10 don't know what the patient has taken. They
11 see them in a panic state or a psychotic state
12 or a delirious state, and God knows what they
13 have taken. They don't give the information.

14 THE PUBLIC: You say people
15 use marijuana increasingly and in increasing
16 doses, is that what you are saying?

17 DR. LEON: I say many do.

18 THE PUBLIC: Many do?

19 DR. LEON: I say a certain
20 proportion, and I can't give you the number.

21 THE PUBLIC: Studies have
22 shown that people after taking marijuana once or
23 twice do not necessarily go on to increase the
24 amount of the marijuana they need to get high.

25 DR. LEON: You have got
26 two pools, a very large pool of people who try
27 marijuana, take marijuana once or twice. And
28 some of them might use it once a week and never
29 run into any trouble. You run into another
30 group of people who use it for different purposes,

1 possibly it affects them differently, and they
2 use it very heavily.

3 And you can't tell which
4 one person entering this pool is going to
5 graduate into the other pool.

6 THE PUBLIC: You are talking
7 not about quantity, but the number of times they
8 use it. Is that right?

9 DR. LEON: I am talking about
10 the people who are susceptible, and this is a
11 subject no one is going to be able to measure.

12 And this seems to be a growing
13 number, and anyone who is entering into this
14 particular pool of mild marijuana use, then use
15 it heavier and heavier. And I think in some this
16 might be the case, that there is exposure, there
17 is group pressure; and this is in the literature,
18 that the main reason for using marijuana is
19 exposure and group pressure. If you want to
20 join the gang, use it.

21 And out of this pool, you don't
22 have to be with people who use it heavier and
23 heavier and get into more and more trouble.

24 THE CHAIRMAN: The gentleman
25 here, Doctor, asked what you meant about "heavier
26 and heavier". Are you talking about frequency
27 of use?

28 DR. LEON: I would say
29 frequency, larger use, going on to hashish,
30 this is mentioned in the literature, and then you

1 are on to something very much stronger.

2 THE CHAIRMAN: Professor
3 Silverman?

4 PROFESSOR SILVERMAN: Sorry
5 to intervene again, but a lot of the discussion
6 today, particularly reminds me of the story of
7 the three doctors who were associated in psychia-
8 tric practice and posted a sign that said, "Six
9 couches, no waiting".

10 I think what one is doing
11 fundamentally is, the question of the human
12 hang-ups and percentage of society that has one
13 sort of hang-up or another that is going to be
14 expressed one way or another, and that funda-
15 mentally are we going to get into a situation --
16 perhaps this is what we should be doing -- where
17 all of us are given some sort of training in the
18 morning, you know, serve as the ambulatory
19 psychiatric assistant to my neighbour, and then
20 we take a turn in the afternoon.

21 My wife worked while I was
22 a graduate student for the psychiatric institute,
23 and she came back one day and said, "You know,
24 [Fritz Readily] said something very good. He said
25 what this country needs is millions of five
26 dollar a day psychiatrists".

27 So I think that this point
28 has to be put into perspective, and I am sure
29 that the Commission has got it ⁱⁿ /perspective, and
30 that is that there are fundamental hang-ups and

1 predispositions; that we are going to have some
2 of us acting out as alcohol or sedative addicts,
3 at times at least. Others of us, such as
4 myself, are going to be food addicts. I may
5 just be on a stringent diet. And we are going
6 to act out that way, and so on.

7 THE CHAIRMAN: What have you
8 switched to?

9 PROFESSOR SILVERMAN: Work.
10 Well, thank you.

11 THE CHAIRMAN: Thank you.

12 Any other questions or
13 comments? Thank you very much, Dr. Leon.

14 I call now on the Federation
15 of Labour represented by Mr. Baker.

16 For the benefit of those who
17 are wondering how our schedule is going, we are
18 to hear after this order, the Home and School
19 Association, Mrs. Gleeson; the Knights of Columbus,
20 and the Nurses' Association. I think if there is
21 anyone else who wishes to be heard, I would
22 appreciate it if they would let our Secretary,
23 Mr. Moore, know.

24 Excuse me. Mr. Baker?

25 MR. BAKER: Mr. Chairman,
26 members of the Commission, I welcome this
27 opportunity of appearing before you to present
28 our views on such a critical matter as this.

29 Drug use among the young
30 has spread from the relatively few isolated cases

1 in the early 60's to the alarming proportions
2 attained today. While known figures appear to
3 show that the drug problem is on the university
4 campus and high schools, this only gives the
5 known cases where drug misuse appears to be.

6 The urban areas, small
7 towns and villages, do not seem to have been
8 by-passed because availability of the drug has
9 become more widespread than in the 50's. Drug
10 misuse cannot be pinned down to the class lines,
11 as was the case in the past. It is no respecter
12 of class and with the availability of so many
13 and varied types of drugs, price is not confining
14 it to the different classes. The pushers, old
15 and young, selling these drugs are the worst
16 sort of parasite that society has ever had the
17 displeasure of tolerating.

18 The new majority, as the
19 young are called and so it seems, because over
20 50% of this country's population is under 25
21 years of age, have many new adages which are
22 merely extensions of old cliches which the
23 older generation went around canting. "A pill
24 for every ill and only a swallow away"; adults
25 are old fashioned, new morals to keep up with
26 the twentieth century, etc.

27 The thought of legalizing
28 such psychoactive drugs as cannabis makes our
29 blood run cold. The thoughts of youth creating
30 their own counter-culture based on drug use,

1 leaves something less than to be desired. On
2 our highways, cities, towns and villages, the
3 police have their work cut out for them now
4 without adding further to their duties.

5 The coverage given by the
6 mass media of the illegitimate use of drugs by
7 juveniles may even be a deterrent to the fact
8 that there are many so-called responsible
9 adults who are "hooked", so to speak, on drugs;
10 the housewife taking painkillers for headaches
11 that might come, the appetite suppressants for
12 those who are afraid of becoming fat, the business-
13 man taking tranquilizers at the least sign of a
14 minor crisis.

15 The medical profession has
16 already been well informed about the substances mis-
17 used by adults and their hazards should be well
18 known, if not always adequately considered. But
19 on the other hand, many of the substances
20 used by youth are relatively new or their method
21 of use is new. The doctors and the general public
22 are, on the whole, inadequately informed con-
23 cerning their effects and dangers. However, of
24 all of these drugs used, alcohol has long been
25 the chief hazard for our youth because of its
26 extensive legal misuse.

27 The worst feature of drug
28 use is the dependence which comes, either psychic
29 or physical, and this clearly appears to be the
30 case after extended use.

1 Dr. F. W. Lundell, Associate
2 Professor of Psychiatry at McGill University
3 states, "All young people on drugs have a few
4 things in common. Their motor performance and
5 perceptual organization is quite poor; a group
6 of high adolescents were given a simple recall-
7 perception task - a seven year old child used
8 as a control subject by far outdid the drugged
9 youths".

10 The problem as we see it, is
11 not what to do with these people when on narcotics
12 or as in so many other cases, how to fix or
13 remedy the situation after it has occurred, but
14 how to prevent this problem from ever happening
15 in the first place. That is our foremost objective.
16 It would seem as though this would be an insur-
17 mountable task, but we already have certain
18 machinery to work with and through.

19 First, there is allied youth
20 doing a very good job of making use of information
21 made available by Alcoholics Anonymous. We also
22 can have coverage through radio, television and
23 the press; what we need now is an educational
24 program for adults and children alike, in schools,
25 service clubs, churches, Boards of Trade, and
26 other places where people gather to explain,
27 acquaint and give people the chance to consider
28 the effects of this problem.

29 Our next task is for us as
30 parents to communicate with our young people.

1 We must listen to what they have to say and
2 not brush them off with, "Don't bother me now"
3 or some other evasive answer. If parents can
4 keep talking with their children right through
5 adolescence to adulthood many problems would
6 cease to exist.

7 The governments, federal and
8 provincial and municipal, must also do their
9 part in the educational program. Bigger and
10 better health centres are needed, extended
11 studies into these various habit forming drugs
12 and what possible long range complications can
13 occur. Everyone should remember the drug,
14 thalidomide, and the dire effects it had on the
15 unborn children of pregnant women; or the man
16 who gouged out his eye and severely impaired
17 the vision in the other eye because of the
18 hallucinations which he saw while under the
19 effects of LSD. Studies must be made, information
20 compiled and made available to society so that
21 they might look before they leap.

22 Youth are adventuresome and
23 anything is a challenge, but if several go some-
24 where and get a narcotic such as marijuana the
25 one who buys is not necessarily a pusher and
26 the others conspiring to traffic, and this seems
27 to be what the law states.

28 We by no means condone
29 narcotics but an offence of this nature receives
30 such a harsh penalty while the real pusher continues

1 to roam at large, and by a pusher we mean someone
2 who is doing just that; pushing narcotics and
3 literally singing their praises but not wanting
4 nor using them for himself.

5 Youth, as a whole, are
6 extremely inventive, as we can all well realize
7 when we see the ways in which they have sub-
8 stituted and made variations in the use of
9 narcotics, such as using a pill for schizophrenia
10 to prevent a bad trip on LSD. We only wish that
11 this inventiveness could be channeled into some-
12 thing of a more constructive nature which would
13 be of benefit to us all.

14 Our parent body, the C.L.C.,
15 will be making further presentations and we will
16 also be on record as being in support of their
17 submission.

18 THE CHAIRMAN: Thank you,
19 Mr. Baker.

20 Dean Campbell?

21 MR. CAMPBELL: Was this brief
22 prepared by the Executive of the Federation of
23 Labour?

24 MR. BAKER: Partially.

25 MR. CAMPBELL: What other
26 sources did you use?

27 MR. BAKER: Newspaper
28 clippings, a report put out by Dr. Unwin, and
29 part of a report by Dr. Yolles.

30 THE CHAIRMAN: I don't under-

1 stand what you mean by "partially". Is it a
2 brief on behalf of the Prince Edward Island
3 Federation of Labour?

4 MR. BAKER: Yes, it is.

5 THE CHAIRMAN: Has it been
6 approved by the Federation?

7 MR. BAKER: Yes.

8 MR. CAMPBELL: Do you remember,
9 off hand, the reference for that study?

10 MR. BAKER: That came out of
11 the Montreal Gazette, January 17th, 1970.

12 MR. STEIN: In reading the
13 last part of page 3, I am wondering what your
14 recommendations here are relating to present laws
15 on use of the drug. In other words, it sounded
16 as though you are wanting a harsh penalty for the
17 professional organized criminals who are involved
18 in pushing. Is this right?

19 MR. BAKER: Yes.

20 MR. STEIN: What is your view
21 about -- in the paragraph before that you talk
22 about young people being adventuresome and
23 everything being a challenge. Do you believe
24 the present laws as they stand are appropriate
25 and should remain as they are for persons who are
26 using the drug?

27 MR. BAKER: Well, I think the
28 present laws were drawn up when perhaps the
29 dominant drugs on the market were heroin and
30 morphine, and I don't really feel that they are

1 appropriate to today's standards. I feel that
2 they should be revised a trifle and not really
3 nail the person who is going to try some of this.

4 Some people will try it
5 anyway, but I don't think it should be quite as
6 harsh as it is.

7 MR. CAMPBELL: If you look
8 on page 3 of your brief, when you talk about
9 education programs for adults and children alike,
10 "what we need now is an Educational Program for
11 adults and children alike in schools, service
12 clubs, churches, Boards of Trade and other places
13 where people gather to explain...", there is
14 no mention of trade unions. What was the reason
15 for not including trade unions as one of the
16 vehicles ^{through} / which education could take place?

17 MR. BAKER: Well, I would
18 say off-hand, that that would come through the
19 people themselves. They would be caught up in
20 the churches and service clubs and you pretty
21 well have the trade unions there. If you want
22 to extend it to trade unions, by all means do so.

23 MR. CAMPBELL: It wasn't a
24 deliberate omission, of the trade union not
25 having the responsibility or wanting to play an
26 educational role?

27 MR. BAKER: No, I thought
28 that you had the trade unions working through
29 just about any place that the people gather; you
30 usually find a trade unionist in there as well.

1 THE PUBLIC: You use the
2 terms, "dependent" and "narcotic". I wonder
3 what you mean by the term, "dependent" on a
4 drug. For example, is it the same as being
5 addicted to it? And I was wondering, medically,
6 is marijuana considered a narcotic?

7 MR. BAKER: Well, not being
8 a doctor, I consider that I am addicted to
9 cigarettes, and I would consider anybody who
10 required marijuana to be addicted to it and
11 dependent on it.

12 THE PUBLIC: You can't become
13 addicted to LSD or marijuana, as far as I know.

14 MR. BAKER: There are several
15 studies out that say you can. Who do we believe?

16 THE PUBLIC: I know those
17 studies are there, that say you can become
18 addicted to marijuana.

19 THE PUBLIC: I think Dennis
20 is getting at psychological and physical addiction,
21 possibly.

22 MR. BAKER: Well, I imagine
23 you can become physically addicted or psychologi-
24 cally addicted.

25 THE CHAIRMAN: Mr. Baker, I
26 want to understand your recommendations concerning
27 the law. I see at the bottom of page 3, the top
28 of page 4 -- you say that you by no means condone
29 narcotics but an offence of this nature receives
30 such a harsh penalty when the real pusher continues

1 to roam at large, and so on. Now, what is the
2 proposal of your Federation with respect to the
3 present law on marijuana, if any?

4 MR. BAKER: Well, not to be
5 allowed to go completely scot-free, but that he
6 receive a lesser penalty under the law than they
7 receive now.

8 THE CHAIRMAN: You propose
9 a lesser penalty. Are you making any distinction
10 there between the different effects of this?
11 For example, between possession for use or for
12 trafficking, do you make any distinction?

13 MR. BAKER: Well, possession
14 for use rather than for trafficking. There are
15 people who could make a hundred gallons of
16 moonshine for their own use, and there are people
17 that make a hundred gallons to sell.

18 THE CHAIRMAN: Any other
19 questions?

20 Thank you very much, Mr. Baker.

21 We call now upon the Home and
22 School Association represented by Mrs. Gleeson.

23 Mrs. Gleeson?

24 MRS. GLEESON: The Provincial
25 Federation of Home and School Associations wishes
26 to go on record as being strongly in favour of
27 postponing the legalization of marijuana until
28 much more is known about the possible harmful
29 effects of its use.

30 It is our understanding that

1 findings in recent months clearly indicate that
2 there are serious problems in the use of marijuana.
3 Only Thursday an account appeared in the press
4 of two young hitchhikers beating up the woman
5 who picked them up, gave them a ride and fed them.
6 Her kindness was repaid when she was brutally
7 beaten and left unconscious. The two youths
8 said they remembered nothing and admitted they
9 were "stoned out of their minds" on hashish.
10 Hashish is, after all, marijuana.

11 Are we prepared to take such
12 a calculated risk as a society? By one step we
13 create a thousand more potential criminals. Having
14 polluted our lakes, our streams, our atmosphere,
15 we now seem bent on polluting all humanity. We
16 speak of freedom of choice, but we are all too
17 well aware that there can be no real freedom -
18 without legislation. We must ask ourselves,
19 "Supposing the government did legalize marijuana
20 at this time? What are the chances of having the
21 decision reversed later?" Practically impossible.

22 It is our opinion that what
23 is needed is: 1) Ease the penalties on youthful
24 first offenders; 2) Increase the severity of
25 penalties against pushers; and 3) Have a strong
26 educational program on the dangers of the use of
27 drugs.

28 The Provincial Federation of
29 Home and School Associations of Prince Edward
30 Island, therefore wishes to state as follows:

Owing to the lack of research and objective evidence as to the long range effects of marijuana, and in view of the latest evidence of measurable harmful effects, we should like to go on record as being against legalization of marijuana at this time, and to strongly urge that any decision to legalize it be restrained until more study has been carried on.

Furthermore, that in view of the fact that Home and School is concerned for the total well-being and welfare of children, we respectfully ask that the Criminal Code be revised with respect to the rights of individuals, particularly as they refer to adolescents. Our present Criminal Code seems to penalize youthful first offenders unduly. They cannot get a job in the Civil Service, for instance, if they have a narcotics conviction.

Our presentation has been very brief, Mr. Chairman, because we were told that some facts and documentations would be presented, as they were this morning in the Attorney General's report. We were asked to make our personal views known. At this time I would like to say that we represent some fifty associations in Prince Edward Island with a membership of about 2000.

THE CHAIRMAN: I'm sorry, could you give me those figures again?

MRS. GLEESON: Fifty local associations across the Island with 2000 membership.

1 THE CHAIRMAN: All right.

2 Back in October, at our
3 hearing in Toronto, we received a submission on
4 behalf of the Canadian Federation of Home and
5 School Associations and we learned -- we received
6 copies of a resolution that had been adopted at a
7 national level. I regret to say that I at this
8 moment do not have the exact details in my mind,
9 and I don't trust myself to try and summarize it.

10 Our impression at this moment
11 is that it was advocated that there be a change in
12 the legal approach to marijuana.

13 MRS. GLEESON: This was the
14 resolution that was passed by the Canadian Home
15 and School Federation meeting in Toronto in July
16 last.

17 THE CHAIRMAN: Right.

18 MRS. GLEESON: And was addressed
19 to the federal Department of Justice. "Whereas
20 present research findings do not conclusively
21 prove or disprove harmful effects of marijuana,
22 and whereas possession of marijuana is an offence
23 under The Narcotics Control Act which dictates
24 severe penalties; and whereas the severe penalties
25 imposed have a negative effect on the future of the
26 individual; and whereas the imposition of severe
27 penalties for an offence which is rooted in incon-
28 clusive research leads to an alienation of youth
29 from the law-making and law enforcing bodies of
30 the country; and whereas this alienation of youth

1 presents a severe threat to the future develop-
2 ment of the nation; therefore, be it resolved
3 that the federal Department of Justice while not
4 condoning the use of marijuana, remove, for the
5 reasons above, the regulation of marijuana from
6 The Narcotics Control Act and place it under The
7 Food and Drug Act, until such time as conclusive
8 research dictates otherwise."

9 THE CHAIRMAN: Thank you.

10 Do you, as a provincial
11 federation, still subscribe to the substance of
12 that resolution, or have you altered your view
13 in any way?

14 MRS. GLEESON: Not essentially,
15 except for the opening remark where we say that
16 research findings do not conclusively prove or
17 disprove. There has been, of course, considerably
18 more information produced since this July date,
19 including Dr. Yolles report, which was, of course,
20 not available at that time. But it does not alter
21 our feeling that this should come under Food and
22 Drugs rather than under Narcotics Control.

23 MR. STEIN: Did you say
24 Dr. Yolles?

25 MRS. GLEESON: Yolles. Y-o-l-l-
26 e-s.

27 THE CHAIRMAN: What do you
28 understand or hope for from the transfer to the
29 Food and Drug Act in terms of --~~in~~sofar as the
30 effects of punishment are concerned? What do you

1 hope for from the transfer to the Food and
2 Drug Act?

3 MRS. GLEESON: Well, may I
4 again quote, "essentially that young offenders
5 need not have their lives ruined by prison
6 records; that treatment and rehabilitation be
7 stressed instead of punitive measures; and that
8 research be undertaken into the results of the
9 usage of marijuana to clear up the present con-
10 fusion that exists".

11 Essentially, it is the puni-
12 tive measures against ^{youth} and often first offenders
13 that we are trying to have changed.

14 THE CHAIRMAN: Do you propose
15 the removal of penalties altogether insofar as
16 first offenders are concerned?

17 MRS. GLEESON: Possibly, on the
18 first offence, yes, they could be given a sus-
19 pended sentence with a very grave warning of the
20 dangers.

21 THE CHAIRMAN: Would you leave
22 that to judicial discretion?

23 MRS. GLEESON: Certainly,
24 most certainly. It must be. After all, we are
25 not a law enforcement body.

26 THE CHAIRMAN: What I wanted
27 to know, would you make it clear in the legislation
28 or would you want to leave it to judicial discretion?

29 MRS. GLEESON: I think it would
30 have to be left to judicial discretion, having in

1 mind the particular circumstances involved.

2 THE CHAIRMAN: In other
3 words, would you like it to be still possible,
4 though, for a first offender for possession for
5 use, to be sentenced to imprisonment if the judge
6 felt ---

7 MRS. GLEESON: No, I would
8 change this.

9 THE CHAIRMAN: Would you like
10 to remove this?

11 MRS. GLEESON: We are against
12 prison sentences for first offenders.

13 PROFESSOR BERTRAND: You would
14 keep the criminal sanctions?

15 MRS. GLEESON: It is against
16 the criminal records -- it is because of this
17 criminal record we wish it changed to The Food
18 and Drug Act.

19 PROFESSOR BERTRAND: The Food
20 and Drug Act doesn't take care of that.

21 MRS. GLEESON: We are not in
22 favour of the youthful first offender being
23 saddled for life with a criminal record because
24 of one evening of irrationalism.

25 THE CHAIRMAN: Would you remove
26 the possibility of the first offender for possession
27 for use having a criminal record at all?

28 MRS. GLEESON: Yes.

29 THE CHAIRMAN: You would like
30 to remove that possibility from the Criminal Code?

1 MRS. GLEESON: Yes.

2 THE CHAIRMAN: What do you
3 feel about subsequent offenders of possession
4 for use, simple possession?

5 MRS. GLEESON: I think that
6 again, it was not our intent to formulate the
7 laws.

8 THE CHAIRMAN: No, I appreciate
9 that.

10 MRS. GLEESON: Judicial bodies
11 would have to decide on how this should be handled.
12 But our main concern was with youthful first
13 offenders and the fact that this would ruin their
14 whole lives, in effect.

15 THE CHAIRMAN: Yes, I mean,
16 I agree with you that it is not so much the
17 technical -- how this is to be done, as to under-
18 stand your policy. As I understand it, you are
19 content to leave -- to have it possible that second
20 or subsequent offenders of possession for use
21 may be penalized. You are content to leave that
22 possibility?

23 MRS. GLEESON: May be pro-
24 secuted, yes.

25 THE CHAIRMAN: Are there any
26 other questions?

27 Would you like to go to the
28 mike?

29 THE PUBLIC: Madam, you
30 mentioned that you would like to see the penalties

1 lengthened for youthful first offenders, is that
2 correct?

3 MRS. GLEESON: Lengthened?

4 THE PUBLIC: Sorry, diminished.

5 MRS. GLEESON: Yes.

6 THE PUBLIC: Why do you use
7 the word, "youthful" if it is a first offender
8 and he is sixty-five, we will say. You know, would
9 that change your view?

10 MRS. GLEESON: I do believe it
11 would change our view, because, after all, a person
12 of sixty-five is supposed to be a responsible
13 citizen and someone sixteen could be very easily
14 led by his colleagues.

15 THE PUBLIC: But, legally
16 speaking, where do you define the line where you
17 are supposed to know what is right and what not?

18 MRS. GLEESON: Is the legal
19 age not twenty-one?

20 THE PUBLIC: Are you going to
21 set another twenty-one year old age limit?

22 MRS. GLEESON: Well, I think
23 you have to accept the fact that we do agree that
24 twenty-one is the legal age when one enters
25 maturity, don't we?

26 THE PUBLIC: Legally, yes.
27 That is a fact. Otherwise, it is disputable.

28 PROFESSOR BERTRAND: It is not
29 a fact. The penal majority is not twenty-one in
30 this country. It is eighteen in some provinces,

1 seventeen in others and sixteen in others.

2 THE PUBLIC: You said that
3 you didn't want marijuana legalized because not
4 enough research has been done, but yet you say
5 we should be educating our young people on the
6 dangers. Now, how are you going to educate on
7 the dangers if you are not going to have enough
8 research to know what the dangers are?

9 MRS. GLEESON: I think this
10 incident of the other day, and some comments that
11 our Attorney General made this morning are enough
12 surely, to make youth pause and think, do they
13 want to get themselves into this condition where
14 they don't know what they are doing, where they
15 are not responsible for their actions?

16 THE PUBLIC: Well, there are
17 two points ---

18 MRS. GLEESON: This is not,
19 surely, the best we can do in anything, is it?

20 THE PUBLIC: The first thing
21 is, they could have been lying and using hashish
22 as an excuse for what they did; second of all,
23 they may well have done it if they hadn't been
24 using hashish. Had they been using, for instance,
25 whiskey?

26 MRS. GLEESON: This is a
27 possibility, but I think they established, this
28 afternoon, whiskey is also a drug, isn't it?

29 But you take the case of this
30 Salazar child of twelve; surely this child of

1 twelve should not be prosecuted under the criminal
2 laws for having used drugs, should she; marijuana
3 or LSD or whatever she did use? She is a minor,
4 and she should not bear a criminal record because
5 of this, should she?

6 But is she not a good case
7 in point against the use of the drugs, amphetamines,
8 LSD, speed, whatever you wish to call them?

9 THE PUBLIC: I don't think even
10 the people who are advocating the legislation would
11 put amphetamines in the hands of twelve year olds.
12 I think you would get pretty unanimous agreement
13 on that.

14 MRS. GLEESON: Yes.

15 THE PUBLIC: Final question:
16 Was this policy, this brief you presented, formu-
17 lated at the, if you'll pardon the expression,
18 "grass roots" level of your organization?

19 MRS. GLEESON: Unfortunately
20 there was not time to go over the whole members
21 of the Association on this, but the matter has
22 been raised at annual and semi-annual meetings on
23 several occasions, and it is our general feeling
24 that this is the way it should be handled. And,
25 as you have been informed, this was also formulated
26 as the national policy of the Home and School,
27 representing a membership of 200,000 members
28 across Canada.

29 THE PUBLIC: Was this particular
30 brief drawn up by the Executive?

1 MRS. GLEESON: Yes. This was
2 drawn up and presented to all provincial organizations
3 across Canada.

4 THE PUBLIC: The brief you just
5 read?

6 MRS. GLEESON: No.

7 THE PUBLIC: The brief you read,
8 was it prepared by the Prince Edward Island branch
9 of the Home and School?

10 MRS. GLEESON: Yes.

11 THE PUBLIC: The Executive?

12 MRS. GLEESON: Provincial
13 Federation, yes.

14 THE PUBLIC: I mean by the
15 provincial delegation?

16 MRS. GLEESON: Yes.

17 THE PUBLIC: Thank you.

18 THE CHAIRMAN: Thank you.

19 I call now on the Knights of
20 Columbus, represented by Mr. W. J. Smith.

21 Is Mr. Smith here?

22 In that case, I shall call
23 upon the Nurses' Association, represented by
24 Mrs. Bolger.

25 MRS. BOLGER: Mr. Chairman,
26 members of the Commission, I am here as the
27 representative of the Association of Nurses of
28 Prince Edward Island. There are 700 members, and
29 we evidently were not on your mailing list because
30 we didn't know that you were having this hearing

1 in Charlottetown until quite recently. And we
2 had an Executive meeting during the past week and
3 discussed the non-medical use of drugs. We are
4 all nurses and we have had some experience in
5 the care of patients who have used drugs and have
6 been treated in hospital. But we did not have an
7 opportunity to do any kind of research.

8 We did read some recent research
9 findings on the physiological and psychological
10 effects of marijuana because we understood that
11 the federal government is under a good deal of
12 pressure right now to legalize marijuana. We would
13 like to present a written brief to you later when
14 we have had opportunity to do further study, and
15 when the whole group, that is, the branch organiza-
16 tions, are able to discuss the problem.

17 But as a result of our study
18 and discussion during the last week or so, we
19 support the position taken by the Attorney General
20 and until further study is carried through, we
21 agree that marijuana should not be legalized and
22 that more research in connection with this is
23 necessary, and that education of the people regarding
24 the effects of the drug is imperative.

25 We also agree with the recom-
26 mendation that there be liberalization of penalties
27 to the first offender or the young person who is
28 experimenting with the use of drugs, and that there
29 be maximum penalties of the law for those who are
30 promoting the sale of marijuana.

1 I wonder at this time if I
2 could ask, is there a deadline on the date for
3 submissions?

4 THE CHAIRMAN: No, we have
5 no deadline fixed, Mrs. Bolger. We have to make
6 a final report around, I suppose, the end of May
7 or so, 1971, but I think probably we could say
8 that almost any time up to the end of 1970 would
9 be convenient for us.

10 MRS. BOLGER: I would just
11 like to comment that I understand the young people
12 in the high schools are doing some study on drug
13 use in the high schools, and there will be some
14 report coming from them.

15 I have a teenage daughter and
16 I am sometimes appalled that at sixteen -- not too
17 long ago she came home and said, "Well, I know
18 someone who has taken marijuana". And I said,
19 "Well, what effect did he have from taking this?"
20 "Well", she said, "Sort of a Disneyland effect,
21 he was floating". And she said she has learned
22 at school that really it is not a harmful drug.

23 THE CHAIRMAN: That it is
24 really not harmful?

25 MRS. BOLGER: No, marijuana
26 is not harmful. This is the teenager, and when
27 I talked with her about, well, did she know, that
28 she might have loss of spacial discrimination,
29 that she might step out in front of a car, well,
30 she didn't realize that. There certainly is a

1 great deal of room for education into all of
2 the effects that they may get from this drug.

3 THE CHAIRMAN: Thank you,
4 Mrs. Bolger. Excuse me. Dean Campbell?

5 MR. CAMPBELL: Mrs. Bolger,
6 you said as a result of your meeting last week,
7 the Executive of your Association supports the
8 brief of the Attorney General.

9 MRS. BOLGER: Well, in the
10 studies that we carried through, and reports on
11 recent findings and research, these findings were
12 presented by the Attorney -- some of the same ideas
13 were presented by the Attorney General.

14 MR. CAMPBELL: Did you have
15 access to the Attorney General's brief?

16 MRS. BOLGER: No, but we did
17 have some copies of studies which were probably
18 some of these, in the quotes that he had made this
19 morning. So, when I say that we support what the
20 Attorney General presented this morning, in our
21 discussions these were the ideas that were presented
22 by the members of the Executive too. That is, delaying
23 any legalization of marijuana.

24 MR. CAMPBELL: Essentially,
25 what you are saying is, having heard the Attorney
26 General's brief today, the conclusions of your
27 group are the same as the ones that he had reached?

28 MRS. BOLGER: The recommendations,
29 yes.

30 MR. STEIN: You mention your

1 present desire for increased penalties against
2 those persons who are pushing the drug, is that
3 correct?

4 MRS. BOLGER: Yes.

5 MR. STEIN: At the moment,
6 one of the definitions of trafficking the drug
7 includes the giving of ~~a~~ marijuana cigarette, for
8 example, from one person to another person, this
9 is technically considered trafficking. Would you
10 include in your concern for increasing penalties
11 that kind of activity?

12 MRS. BOLGER: No, I certainly
13 would not think of that. If one teenager passed
14 a cigarette to another, I would not think that is
15 trafficking. I am talking about a person who is
16 motivating young people to use drugs, and we under-
17 stand that there is this, one person who uses the
18 drug tries to proselytise others and have them use
19 it, and talk about the benefits of the drug rather
20 than to speak about any deleterious effects of the
21 drug.

22 MR. STEIN: So then you would
23 also be in favour of some revision of the law as it
24 stands, regarding trafficking?

25 MRS. BOLGER: Yes, I did mention
26 this, that we would hope the maximum penalties would
27 be given to any person who is trying to motivate
28 the sale or to traffic in drugs.

29 THE CHAIRMAN: I don't understand
30 what you mean by "motivate the sale or trafficking

1 or transfer or distribution of the drug". What
2 do you mean; that there should be a penalty for
3 encouraging use of the drug?

4 MRS. BOLGER: I am thinking
5 about the person who is selling the drug in an area.
6 I don't think there would be any possibility of
7 controlling the person who is trying to motivate
8 others to use the drug. It wouldn't be feasible
9 to do this.

10 THE PUBLIC: How do you dis-
11 tinguish between selling and, for example, me going
12 to Montreal and getting three or four dime bags
13 for some friends?

14 MRS. BOLGER: I haven't thought
15 about this, but I should think that if a person is
16 bringing a drug into the area -- you say he is not
17 selling it, he is giving it? He must buy it some
18 place.

19 THE PUBLIC: Well, for example,
20 if I took a collection from my friends and we
21 wanted some marijuana, and I went and bought some,
22 that is almost the same as on the larger scale.

23 MRS. BOLGER: Well, I can't
24 see that, because you are taking their money and
25 buying it; it is the same thing.

26 THE PUBLIC: I am not making
27 a sale in the sense that I am making a profit; I am
28 doing someone a favour.

29 MRS. BOLGER: Well, yes, you think
30 it is a favour, but do you know that there are no

1 harmful effects of the drug? You may be certainly
2 causing this person great harm. You say you are
3 doing them a favour.

4 THE PUBLIC: I think maybe what
5 he is trying to get at is, it seems to me that a
6 person would not be as motivated in using the drug
7 if he was given it as if he bought it.

8 MRS. BOLGER: That is hardly
9 the point. I'm talking about people who are
10 selling it in an area.

11 THE PUBLIC: That is a dis-
12 tinction you did make there, about somebody giving
13 it away as opposed to somebody selling it. I suggest
14 you are equally motivated in whether you are giving
15 it away or if you are buying it.

16 MRS. BOLGER: Well, I think that
17 if you are penalizing people who are motivating
18 others to use the drug, it would be difficult to do
19 anything about this situation. It would be difficult
20 to find out who they are. But, as I say, if people
21 are educated, they know what the effects are and
22 they know that there are harmful effects from it,
23 and are able to make their own decisions. But I
24 think that young people are not educated so they
25 know what the effects of the drug are.

26 MR. CAMPBELL: Mrs. Bolger, I
27 have been struck that in presentations of various
28 bodies today, -- here I am speaking from memory,
29 but there seems to be some consensus that a number
30 of the presentations -- or, it would strike me that

1 some level of agreement is in these submissions,
2 or in many of them. Would it be reasonable to
3 think that this perhaps has a wider base opinion
4 in Charlottetown than simply these organizations?
5 I presume you have talked this matter over with
6 people outside of the Nurses' Association, for
7 instance.

8 MRS. BOLGER: We haven't had
9 any opportunity, actually.

10 MR. CAMPBELL: I am just
11 talking, as an individual, do you think that the
12 Associations/^{view}would be widely held in this community?

13 MRS. BOLGER: I don't know,
14 but just from hearing the presentations today, I
15 would determine that it is held by the people who
16 made the presentations.

17 MR. CAMPBELL: You wouldn't
18 want to go beyond that? You don't have any feeling
19 of the mood of the city or the mood of the Island
20 on this?

21 MRS. BOLGER: I couldn't really
22 make a judgment on that, no.

23 THE CHAIRMAN: Are there any
24 other questions or comments?

25 Thank you, Mrs. Bolger, very
26 much, for your assistance, and thank you all for
27 your attendance and your assistance to us today.
28 It has been for us a most informative session and
29 I am very obliged for the reception we received
30 here. Thank you all. I will adjourn the hearing.

--- Upon adjourning at 5:40 p.m.

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COMMISSION OF INQUIRY
INTO THE
NON-MEDICAL USE OF DRUGS

COMMISSION D'ENQUÊTE
SUR L'USAGE DES DROGUES
À DES FINS NON MÉDICALES

February 21, 1976
Montgomery Hall
University of Prince Edward Island
CHARLOTTETOWN, Prince Edward Island

COMMISSION OF INQUIRY
INTO THE
NON-MEDICAL USE OF DRUGS

COMMISSION D'ENQUETE
SUR L'USAGE DES DROGUES
A DES FINS NON MEDICALES

BEFORE:

Gerald LeDain,	Chairman,
Ian Campbell,	Member,
H. E. Lehmann, M.D.,	Member,
James J. Moore,	Executive Secretary,
Marie-Andrée Bertrand,	Member.
J. Peter Stein,	Member.

SECRETARY TO THE CHAIRMAN:

Vivian Luscombe.

February 21, 1970.
Montgomery Hall,
University of Prince Edward Island,
Charlottetown, Prince Edward Island.

1 --- Upon commencing at 1.05 P.M.

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THE PUBLIC : Ladies and gentlemen, in the absence, at least I think the absence of any representatives of the Student Union, I will take this opportunity to introduce Dean Gerald LeDain, who is the Chairman of this Commission, and then I think we will go right into it.

Dean LeDain?

THE CHAIRMAN: Thank you very much.

If I might introduce my colleagues here. On my immediate left is Dean Ian Campbell of Montreal, Dean of Arts at Sir George Williams; Dr. Heinz Lehmann of Montreal; and Professor Marie-Andree Bertrand, Professor of Criminology at the University of Montreal; and Mr. J. Peter Stein of Vancouver, a social worker and member of the C.Y.C. and a probation officer.

And I am Gerald LeDain, Dean of Law at Osgoode Hall in Toronto. Now I don't know how much you know about our Commission, and I will just for a few moments touch on the highlights and the background of our appointment, and terms of reference.

We were appointed at the end of May last year by the Federal Government. We are an independent Commission of Inquiry. We are asked to make an inquiry into, and report on,

1 the extent of non-medical drug use in Canada and
2 the group of people involved, populations involved,
3 patterns of use. We are asked to report on the
4 current state of medical knowledge concerning the
5 effects of the drugs, and on the causes or larger
6 significance of the whole phenomenon of non-medical
7 drug use, and the meaning of it.

8 Then on the basis of these
9 findings, to make recommendations to the Federal
10 Government as to what it can do, alone or with other
11 governments, to reduce, as it is put, "the dimensions
12 of problems involved in such use."

13 Now we have to bring out an
14 interim report shortly, and then we will bring out
15 a final report around June of next year.

16 So we are here to listen to you,
17 hear from you, get the benefit of how you look at
18 this thing, how you see it from many of those aspects.
19 If they are of particular concern to you, the extent
20 of it, causes, what it means, what is the proper
21 interpretation of it?

22 Then what are we, as/^asociety,
23 what kind of a response as a society are we to make
24 of it? How are we to react to it? What is the
25 sound way to react to it? I mean with regard to the
26 fact that social response does not only include
27 law, it includes many other influences on human
28 behaviour, education, persuasion and our own
29 intelligent exercise of choice which sometimes is
30 expressed as self-control and so on.

1 And so we have no prepared
2 program other than to listen to you, and ask you
3 to give us the benefit of how you see it, and what
4 you think we should -- how we should see it,
5 and what we should recommend, what should be our
6 position on it.

7 So please feel free to help
8 us with your views.

9 THE PUBLIC: What specific
10 drugs are you concerned with?

11 THE CHAIRMAN: Yes, I should
12 have said something about that.

13 We are concerned with what are
14 called the psychotropic drugs and substances and
15 these we have described roughly as the mood-modifying
16 drugs.

17 Now, we haven't made a
18 classification of it, but I suppose we are chiefly
19 concerned with the psychedelics and with cannabis
20 and its various forms, and LSD and the psychedelics;
21 concerned with the amphetamines, other stimulants.

22 We are concerned with the
23 opiates, narcotics, heroin. And we also recognize
24 that alcohol is a mood-modifying drug and comes within
25 our terms of reference.

26 And we are looking at the others,
27 tranquillizers and barbiturates. So it is quite
28 a range.

29 But I think it is true to say
30 that we are increasingly impressed by the

1 importance of alcohol, although as I said in our
2 statement this morning, we sort of felt that we
3 should look at the reasons, what appear to be the
4 reasons for our appointment and our terms of reference
5 stress the more recent use of these drugs like
6 psychedelics and also the volatile substances,
7 delerients they are sometimes called, and known
8 as glue and nail polish remover, and so on.

9 DR. LEHMANN: Might we turn
10 the question around, and ask you what you think
11 we should be primarily concerned with?

12 THE PUBLIC: Well, I think
13 nearly every drug you mentioned there, there is
14 a problem, even the non-drugs like glue and
15 etc., etc., LSD.

16 DR. LEHMANN: That is a wide-
17 spread comment.

18 Where should our priorities
19 be ?

20 THE PUBLIC: I really don't
21 know the alcohol problem. I would say heroin would
22 seem to be the great problem. I don't really
23 know.

24 THE CHAIRMAN: Heroin seems
25 to be the big problem?

26 THE PUBLIC: Not around here,
27 of course, but just what I have read.

28 DR. LEHMANN: Where?

29 Where have you read of it as
30 being a big problem?

1 THE PUBLIC: I can't recall.

2 DR. LEHMANN: In the States
3 it has been a very big problem.

4 THE PUBLIC: I have heard of
5 the problems in very big cities like Toronto and
6 Vancouver, and Montreal.

7 MR. CAMPBELL: In P.E. I.
8 itself do you see a significant drug problem with
9 reference to any of these?

10 THE PUBLIC: I don't see a
11 great problem with drugs like marijuana, as a
12 problem.

13 Perhaps you call the psychedelic
14 LSD, I don't really have any information on that
15 at all. But I don't see it as a problem.

16 THE CHAIRMAN: What do you
17 mean, when you say you don't see marijuana as a
18 problem?

19 It isn't being used, or ---

20 THE PUBLIC: It is being used,
21 but I don't see the harm.

22 THE CHAIRMAN: You don't see
23 the problem.

24 THE PUBLIC: ---

25 DR. LEHMANN: Isn't the
26 problem to get the drug?

27 THE PUBLIC: It is a little
28 bit of a problem.

29 DR. LEHMANN: Well then it
30 would be a problem then.

THE PUBLIC: That's true.

DR. LEHMANN: Is no one getting
busted here?

THE PUBLIC: Some people have
got busted around here.

THE PUBLIC: The trials have
been dragging on for two years, by the way.

It has been postponed and
postponed. I don't know if this is the last
postponement but this is coming up in April again,
and they were originally arrested in, I think, May
or June of 1968.

It is dragging and dragging
on.

THE PUBLIC: (portion inaudible)

DR. LEHMANN: In what way?

THE PUBLIC: University students
are trying to be educated and they come back, and
it is adjourned until later on, you know, it is
immoral and I can't understand why they are doing it.
It is almost as if they gave them a year in jail,
the way they drag things on, I just can't believe
it.

MR. STEIN: Who is asking for
the stay of proceeding, or the delay, or do you
know?

THE PUBLIC: I am not sure of the
reason. Whoever is responsible, I can't understand
why it is being dragged on.

Perhaps the counsel for the

1 defence is doing it. But I don't see why.

2 THE PUBLIC: A number of
3 times, when the jury couldn't come to a decision,
4 well that was one time.

5 THE PUBLIC: That was one time.

6 THE PUBLIC: Could be a lack
7 of evidence.

8 THE PUBLIC: Another thing
9 that is happening is the Crown prosecutor is calling
10 for re-trials and things like that, because the
11 penalties that were given were too light, and that
12 is another problem.

13 THE PUBLIC: I think, in many
14 cases the bad effects come not as much from using
15 the drug as from having to go to prison and get
16 bad publicity, criminal record.

17 Like in a case I know, this
18 person, his family was really shaken like when
19 they came in and arrested him, and his mother
20 had a very traumatic experience over this.

21 He was arrested in his house.
22 He was a college student, and, I don't know,
23 I think he was in the upper-range scholastically,
24 you know, was very intelligent and aware person.

25 I don't think the drug user is
26 sort of the scum of society or the lower class
27 person, you know, someone from the Harlem slums or
28 something. This is the sort of person you get
29 using marijuana. Granted there are curious people,
30 and there are, say very young people who are, you

1 know, looking for kicks and what not, but I think
2 if marijuana was legalized, and it was under govern-
3 ment control, and was, like cigarettes, there were
4 government standards set for it, a lot of bad things
5 that are involved would disappear and people
6 might not -- some young kids probably start taking
7 marijuana and other drugs because apparently of the
8 thrill of doing something that is slightly illegal,
9 and there is sort of a clandestine feeling about it.

10 I mean pushing in dark alleys
11 and things like that, and I think it is part of the
12 attraction for some people, but I think in the college
13 ranks that it is not the attraction at all.

14 I think people in college,
15 and professional people, you know, I don't think
16 they are so immature that they are using it because
17 it is illegal, or anything like that.

18 I think that they would be
19 very happy to see it legalized.

20 DR. LEHMANN: The other way
21 around, though, are there some students who don't
22 use it because it is not legal, who would use it if
23 it was legal?

24 THE PUBLIC: Yes.

25 I would definitely say there
26 were.

27 DR. LEHMANN: Then that would
28 mean more students would use it if it became
29 legalized.

30 THE PUBLIC: I think that is a

reasonable assumption.

DR. LEHMANN: Would you consider the possibility there may be more problems than there is now, if more people used it?

THE PUBLIC: Well, I don't encounter a great range of problems with the people I know right now. I don't think they are problematic. I don't think they are apathetic, I think they are involved in many things.

And usually, I think around here it is an occasional thing, it is not a habit thing, like going out and having a few beers on Friday night, or something.

It is not sort of a thing that you can plot. It just occasionally happens.

DR. LEHMANN: What would you this is the percentage or proportion of students?

THE PUBLIC: I would say out of seventeen hundred, there would probably be a hundred and fifty that have used at one time or another illegal drugs.

There is probably thirty or forty that use illegal drugs with some regularity, say, more than five times a year.

DR. LEHMANN: That is only about three percent.

THE PUBLIC: Yes. That is of course an estimate. It is not necessarily very close.

THE PUBLIC: I am wondering if

1 I could direct a question now?

2 Is this supposed to be a learning
3 process for both people? I am wondering what
4 experiences they have had in countries where
5 marijuana is legal? Haven't they learned how to
6 cope with it in these countries?

7 DR. LEHMANN: Well, I don't know.

8 THE CHAIRMAN: Well, I wanted
9 to answer the question about whether this is a
10 learning process, or both.

11 My first impulse was to say yes.
12 I think it was probably set up -- but let me just
13 explain our problem. We are asked to report. It
14 is indicated the proper form and the proper
15 time which we are required to report and we are to
16 express our judgments in the form of reports so
17 it is improper for us to express conclusions other
18 than in that form in the course of our hearings.

19 On the other hand, it's obvious^{we}/
20 can't
21 / inquire unless we disclose something of our
22 perspective, something of what we consider to
23 be relevant. By the questions we ask we begin
24 to indicate some relevance. So there is a certain
25 degree of mutual learning in it, but we do have
26 this handicap that for example we wouldn't have if
27 we were a panel of people who would come and talk
28 on drugs.

28 So on that question, you see,
29 that raises the question, quite frankly raises
30 the question as to what our conclusions are at

1 the present time as to the effects, short-term and
2 long-term, of marijuana.

3 And if we try to answer that
4 question, we would have to express our judgment
5 on the relevance and so on, and the foreign
6 experience with it and on the reliability of the
7 studies on it.

8 I took some time to tell you
9 that, to give you an idea of our particular bind,
10 as far as the expression of opinions are, but
11 we don't want to just clam up completely.

12 THE PUBLIC: What I am trying
13 to get at is there seems to be some apprehension
14 if marijuana was legal it would be even used on a
15 widespread basis, and there doesn't seem to be
16 very much information concerning what has happened
17 when it is used on a widespread basis, and I am
18 just wondering if that might be something which the
19 Commission might consider significant.

20 THE CHAIRMAN: It is very
21 relevant.

22 The question is very relevant
23 to be able to estimate what would be the extent
24 of use, both dose levels, let us say, and frequency
25 under conditions of availability, assuming that one
26 were to decide that it should be available.

27 It is very relevant to determine
28 what would be the use.

29 What do you think would be
30 the use? What do you think would be a likely regular

1 use of marijuana, if it were available, say, in
2 the smoke form of cigarettes?

3 THE PUBLIC: I think it would
4 be easier to say, and I think you could say so with
5 a certain degree of validity, that in our North
6 American culture, if you want to call it that, we
7 have kind of a proneness to use things in excesses.

8 I think everything we do is
9 excessive, so I think my personal point of view before
10 it could be legalized, I think there should be
11 something done to help the culture prepare for such
12 a legalization.

13 I think we have all seen what
14 happens when alcohol etc. is available. It is
15 abused by many people. So I think there has to
16 be some kind of a learning process to prepare
17 people culturally, to accept such a traumatic
18 experience as we might have if we legalized
19 marijuana.

20 Mind you, I am for legalizing
21 marijuana; I am also for government standards much
22 like there are on liquor, and things like this.
23 But I am wondering, are we ready?

24 You know, could there be something
25 to prepare us for such an experience?

26 PROFESSOR BERTRAND: What sort
27 of inner controls can we develop before it is
28 available?

29 DR. LEHMANN: What for instance,
30 could be done to prepare ourselves culturally for it?

THE PUBLIC: I really don't know.

I think a basic change in our life-style.

I think that is, you know, has to be changed.

DR. LEHMANN: How do you go about that? The American way of life, how are you going to change it?

THE PUBLIC: That is probably the problem with our life. I couldn't really give you details on how it could be changed. I think a lot of the basic assumptions that we make in our culture would have to be changed.

Things like the competition, like this, you know, this rush, rush world we live in, I think this is what causes the tendency to consume, consume, consume in excess.

People have to do everything rapidly, and there is only so much time, so I have to assume as much as I can in that time.

We have a different way of life than they have in places like Morocco, where it is legal. or other places where it is legal, and I think we have to do something, you know, we have to undergo basic changes in our society to prepare for such a thing.

THE PUBLIC: If I could comment on this, looking at the people that are taking it, I would generalize and say, people who are taking it, and dropping it are coming back in like the hippies, the students, seem to be very aware, and

1 concerned groups of people people perhaps who have
2 a large role to play in their adulthood and government
3 and things like that, but do you think this would
4 come whether it were legalized or not, would change
5 the society a great deal, like the person you are,
6 and taking marijuana?

7 THE PUBLIC: If you are addressing
8 the question to me, I don't share the basic premise
9 people taking marijuana right now are going to be the
10 people to lead us in the future.

11 I think rather, that people who
12 are taking marijuana now -- I will say a group of
13 them -- I won't go so far as to say a vast majority,
14 but I say there is a majority who are seeking to
15 find themselves within themselves, not necessarily
16 within society, and I don't think -- I don't think
17 these are the people that are going to lead us in the
18 future.

19 I don't think the drug-takers
20 today, for instance the marijuana smokers are any
21 more apt to be the leaders of tomorrow than anyone
22 else.

23 I think probably less so, because
24 they, in many cases, have found it rather impossible
25 to live in our society without seeking this type of
26 an escape.

27 THE PUBLIC: I don't agree with
28 your assumption that the majority of marijuana
29 smokers are doing it to find themselves.

30 This keeps cropping-up.

1 THE PUBLIC: To control themselves,
2 because they can't control their experience in real
3 life due to, as I have said before the limitations
4 that society places on one.

5 THE PUBLIC: I don't agree with
6 that either. I think it is largely for recreation.
7 And I think a lot of the reason it is being suppress-
8 ed is because, you know, to quote H. L. Lincoln, it
9 is a haunting affair that someone somewhere may
10 be happy. I think that narcotics officers could be
11 put to much better use if they were getting
12 themselves in with Mafia people.

13 I mean undercover positions,
14 rather than destroying college kids lives.

15 I think that if you took the
16 number of people who are in narcotics activity
17 chiefly on, say, marijuana activity, and put them
18 into, say Metropolitan Toronto in stopping crime,
19 I think they would be much more effectively used.

20 THE PUBLIC: I think that, you
21 know, you have missed my point.

22 My point was in reference --
23 Dennis feels most people taking marijuana are aware
24 of people in our society.

25 Is this correct?

26 I tend to disagree ---

27 THE PUBLIC: I think Dennis
28 said many of the people. I say that many of the
29 people are the people that are not aware. That is
30 my point.

1 THE PUBLIC: That follows if
2 you say many are.

3 THE PUBLIC: But mind you, I
4 am for some kind of government intervention.

5 I am for the legalization of it,
6 you know, because I feel that it tends to lead
7 towards, for instance, the Mafia intervention and
8 things like this.

9 I agree that there are some
10 good points for legalizing it, but that I am hesitant
11 at this time to suggest that it be done, you know,
12 in terms of opening it up for people who aren't
13 culturally ready for it.

14 THE PUBLIC: I would like to
15 also disagree with the point made this morning,
16 that getting involved with marijuana is getting
17 involved with criminal elements who are pushing
18 marijuana, who are also pushing heroin and many other
19 nasties, but I think most people who take marijuana
20 and even other drugs which are more powerful, get
21 them from friends or acquaintances or co-users, and
22 in all cases they are out to make a profit.

23 In some cases they are, but they
24 don't get them from hoods, really. A lot of
25 people get marijuana, and they go directly to the
26 source, and it sort of filters down.

27 I don't think there is -- you
28 necessarily get into a hierarchy criminal element
29 getting marijuana.

30 THE PUBLIC: I don't know if

1 you can comment at this time on what I am going to ask:
2 but for example, the gentleman that got up this
3 morning, and said he would rather turn his back on
4 a Bengal tiger than users of marijuana; do you get
5 many comments like that?

6 THE CHAIRMAN: I don't think
7 we have ever had that one before.

8 THE PUBLIC: Well, he seemed
9 to be very, overtly against any changes at all.

10 Is this a typical reaction of
11 many people who come to your hearings?

12 THE CHAIRMAN: Well, I was
13 particularly struck by his statement that marijuana
14 was the most dangerous -- I thought I heard him
15 correctly -- the most dangerous of the drugs.

16 I haven't heard that one before,
17 either, I don't think.

18 No I don't think that could be
19 said to be typical. I would say probably that, on
20 balance, we have heard less -- I don't know how you
21 measure these things but quantitatively we have
22 heard from fewer people opposed to legalization than
23 we have from people in favour of it or some
24 liberalization of the law.

25 Although in recent months, I
26 think it is true that we have -- I have got an
27 impression of hearing more from people who are
28 substantially in favour of the present legal
29 approach with some modifications of course.

30 So that they seem to be coming

1 forward more, and I guess this morning you would have
2 to say that on balance this morning the weight
3 of opinion expressed in the time available, and I
4 don't know how representative it was, or how much it
5 reflected the opinion of people present, but the
6 weight of opinion expressed in the time available
7 you would have to say, was in contrast by and large
8 to our experience across the country.

9 Or let's say it was at one poll
10 of our experience across the country. It is kind
11 of a spectrum.

12 At some hearings on a given
13 morning we would have an impression of a weight of
14 opinion against the present approach. And in others
15 we might have in the middle of a spectrum a little
16 more sense of even weight, or balance.

17 And this morning of course,
18 we had very strong weight of opinion substantially
19 in favour of the present approach with some modifi-
20 cations.

21 DR. LEHMANN: You also should
22 keep in mind that we have fewer people over thirty
23 than under thirty, so there is a bias in the age
24 range.

25 THE PUBLIC: Don't you notice
26 a contradiction that keeps cropping up in the
27 testimony against it, against legalization of
28 marijuana?

29 Some people say that you shouldn't
30 legalize it, because it makes people very vicious

1 and psychotic and some people say it makes them
2 apathetic, and indifferent.

3 THE PUBLIC: You can't have
4 both.

5 THE PUBLIC: Right.

6 THE PUBLIC: In this exercise,
7 it seems that not only in Canadian society but in
8 American society is going through today is quite
9 similar in nature to what occurred in the 1920
10 prohibition era as far as alcohol goes. And you
11 would almost think now that we are all set to
12 eject ourselves from the prohibition era as far as
13 drugs go in certain areas, and take a more healthy
14 approach, more societal approach whereby people within
15 society who are concerned with drugs today, especially
16 with the rapid advances in technology and everything
17 else, and science, we should be able to introduce
18 ourselves today a system whereby drugs can be
19 controlled, and whereby those people, even like
20 alcohol is today they are excessive in the use of
21 alcohol, can be treated at treatment centres.

22 And I think if the approach were
23 put more on control and on treatment for those that
24 are excessive in their use, that this would serve
25 a far better approach in our society than the hard
26 line approach that we have with legal mechanisms
27 that are involved in the apprehending and convicting
28 people that are involved with either "pushing" or
29 "using" or "abusing" drugs.

30 Prohibition apparently from those

1 people I have talked to that have lived in the '20's
2 say that prohibition really led to a decline in use
3 when prohibition was over and as a result the
4 gradual rise in the '50's and '60's of the
5 prevalence of alcohol again occurred simply because
6 people were finding it hard to keep up with the social
7 conditions of the time.

8 But now today with drugs, I
9 think that people now are becoming more educated
10 and more aware of the implications and the complications
11 than they were in prohibition days, and as a result
12 the parallel of this situation with alcohol should
13 be a more simplified approach for society to take
14 its own value system.

15 THE PUBLIC: What I found
16 rather strange this morning, Mr. Blanchard said
17 one of the reasons why prohibition of liquor couldn't
18 be controlled was because they couldn't enforce it.

19 Yet he must feel you can't
20 enforce the laws on marijuana. He made a statement
21 he didn't feel too many people around Prince Edward
22 Island were taking marijuana, and I would say he
23 is underestimating the number of people who are
24 taking it.

25 It just goes to show that it is
26 very hard for them to enforce the laws and the two
27 statements seem to be definitely contradictory.

28 MR. STEIN: What is your estimate?
29 We just heard as an estimate here
30 at the campus ---

1 THE PUBLIC: I think Jim said
2 it was three to four percent.

3 THE PUBLIC: I would say up to
4 a hundred and fifty have taken it, at one time,
5 and forty or fifty are using it now.

6 MR. STEIN: What do you mean
7 by the larger ---

8 THE PUBLIC: What do you mean
9 by a steady base?

10 MR. STEIN: I said to you, he
11 was underestimating the extended use on the Island
12 here. What would your estimate be outside of the
13 university?

14 THE CHAIRMAN: Could we just get
15 the figures clear on the university? A hundred and
16 fifty have taken it ---

17 DR. LEHMANN: A hundred and
18 fifty have taken it once, and forty or fifty have
19 taken it four or five times.

20 THE CHAIRMAN: How many?

21 DR. LEHMANN: Forty to fifty.

22 THE PUBLIC: There is more
23 people taking -- a higher percentage of the high
24 schools taking some for of a drug which includes
25 alcohol than there is in university.

26 THE PUBLIC: There are more
27 people taking an increasing consumption of LSD,
28 you know, you can make LSD in your basement.

29 Now personally I don't think I
30 can see myself taking LSD regularly, but the thing

1 is it seems to be forcing people to take harder --
2 what I would consider a much harder drug, LSD,
3 unfortunately.

4 I would think a lot of
5 people would remain with marijuana.

6 MR. STEIN: On what do you base
7 your idea that the high school students are taking
8 a greater amount of drugs?

9 THE PUBLIC: Probably observation,
10 rumor, this type of thing. I really don't attend
11 the high school you know, we couldn't say for sure.

12 I would, however, feel quite
13 confident in saying that the high school percentage
14 was, especially in Charlottetown. I won't speak for
15 the places like Surrey, Antigonish, but the real
16 isolated places but the places that are less isolated
17 I would submit are taking it.

18 THE PUBLIC: Perhaps it would be
19 safe to say that the only areas where significant
20 use is in Charlottetown and Summerside, and perhaps
21 the Summerside rate is higher than Charlottetown.

22 THE PUBLIC: I would say it
23 is.

24 THE PUBLIC: I think I would
25 agree with John, that it does have a higher percentage,
26 and I think not only marijuana but the glue which
27 is, you know, I am completely convinced of the damage
28 that glue can do and when kids thirteen and fourteen
29 take glue ---

30 THE PUBLIC: Of course they found

three ten year olds.

THE PUBLIC: The thing is, I am getting at, is why. And I think one of the reasons is that they no longer feel that they have any control over their own futures, so they seek themselves within themselves rather than within the society.

THE PUBLIC: You mean the kids thirteen or fourteen that will try?

THE PUBLIC: Twelve, thirteen, fourteen, they seem to have given up.

There seems to be -- I don't think -- the drug isn't the problem, the problem is why.

THE PUBLIC: I think, if you take glue and even gasoline some people sniff gasoline, you know, that is the problem.

THE PUBLIC: The problem is why, not that they do it.

THE PUBLIC: I think they are just looking for kicks.

Why do they start smoking, why do they drink? They don't know what they are getting into.

THE PUBLIC: Experimenting.

THE PUBLIC: They are curious, they want to find out, they hear about it, they want to find out.

THE PUBLIC: I think it is more than that.

1 THE PUBLIC: Quite a few of
2 the younger kids are out looking for themselves
3 directing it inwards. They are out for kicks and
4 nothing else as far as I am concerned.

5 THE PUBLIC: I think that older
6 people who use such substances aren't necessarily
7 looking for themselves there always seems to be an
8 innuendo of sort of an immature grasping for them-
9 selves when they use marijuana.

10 I think it is largely
11 recreational. I don't think you need to psycho-
12 analyze it at all. They just want to have a pleasant
13 evening sort of thing. I don't think it is the
14 great self-question "Who am I?" I don't think that
15 necessarily arises.

16 I am not saying it is always
17 absent, but this great grasping for self ---

18 THE PUBLIC: The next question
19 is, why wasn't it quite so widespread five years
20 ago, if there hasn't been a drastic change. I am
21 saying there has been a change in our whole society,
22 and you can solve why -- you know, I think looking
23 at the societal structure, that is going to solve
24 why people turn to drugs.

25 I don't think it is for recreation-
26 al purposes at all.

27 THE PUBLIC: Why wasn't it five
28 years ago as well publicized. I am sure the world
29 wasn't in a much significant better state five years
30 ago.

1 THE PUBLIC: You say the media
2 has probably done it.

3 THE PUBLIC: I mean, trying to
4 compare it to a student loan, for God sakes.
5 There are more students getting student loans today,
6 because it is more available, the same with
7 marijuana.

8 THE PUBLIC: I think the media
9 had something to do with it.

10 THE PUBLIC: I agree with John
11 to a certain degree, that, for example our whole
12 technological type of society is closing in on
13 people and people are trying to escape from this.

14 I think this is important when
15 you are considering the question why.

16 But also for experiments,
17 kicks things like that too. I think what you and
18 Jim are saying are not directly opposite, and I
19 want to sort of find the "mean".

20 Different people take it for
21 different reasons.

22 THE PUBLIC: Five years ago
23 alcohol was just as widespread, and as widely known
24 as it is today practically.

25 Well, it was more widely
26 known simply because it was more prominent then.
27 The drugs have taken over since then.

28 Why, you know, in my particular
29 case, and in the case of everyone I know, there was
30 never ever this thing for kicks with drugs, or booze,

1 or anything.

2 You know, why, why that? You
3 know, I think something has changed and I don't
4 think it is just for kicks.

5 THE PUBLIC: I think you are
6 taking an over-analytical approach to this.

7 THE PUBLIC: I think the
8 important thing here is that young people today are
9 more sensitive.

10 Drinking is sort of a pride.
11 Taking marijuana is sort of a communal type -- very
12 close type of thing to do, and I think young people
13 are looking for that for security, and the communal
14 type of thing in their group.

15 THE PUBLIC: Why?

16 THE PUBLIC: O.K., that goes back
17 to what you are saying, but also I think that what
18 Jim is saying for the sake of recreation and that it
19 is also important.

20 I don't think there are two
21 directly -- you can't say strictly because we are
22 a technological society, or because of, you know,
23 just for kicks.

24 THE PUBLIC: I don't like the
25 attempt I see to pin it down to people who are
26 immature who don't know what they are, or are
27 looking for kicks.

28 THE PUBLIC: There is no attempt
29 at that.

30 THE PUBLIC: The feeling I am

getting, is people are trying to pin it down that people who use marijuana are somehow different, or somehow lacking in something.

THE PUBLIC: In many, many cases it is.

I am not saying everybody, I am saying in many cases.

THE PUBLIC: Do you want to give a percentage?

I don't know. I don't doubt that happens, but I am just saying you are overbalancing your emphasis.

THE PUBLIC: I am trying to suggest to you that a twelve year old isn't generally a mature person.

I would submit to you that probably ninety-five percent are going to drugs at twelve years old, simply because they are immature.

THE PUBLIC: And it is the "in" thing to do.

THE PUBLIC: That is immature and that is ninety-five percent.

As it goes higher it might grow a little smaller.

THE PUBLIC: If you look at our whole society then. Everyone is immature because the "in" thing to do is what people do, clothes, all their needs. They are socialized more and more by the society we live in. So if everyone is reacting, doing things the "in" people do, then everybody is

1 immature. Clothes are not necessarily detrimental
2 to yourself. You can change your wardrobe and it
3 is not going to be harmful to you, where drugs would
4 be.

5 THE PUBLIC: Taking marijuana
6 is not harmful.

7 THE PUBLIC: It can lead to
8 something else.

9 THE PUBLIC: As a twelve year
10 old taking -- I am not concerned about the eighteen
11 year old and the seventeen year old guy taking --
12 I am concerned when you legalize it the same thing
13 with booze, you are going to have twelve year olds
14 drinking, you are going to have twelve year olds
15 taking acid and other stuff.

16 This concerns me. At twelve
17 years old you start off at pot, and I think you are
18 going to get kind of bored with it at twelve years
19 old. I am not concerned with the sixteen and
20 eighteen, you know, all this stuff this doesn't
21 concern me, what concerns me is why the kids eleven,
22 twelve, thirteen, fourteen why they have to have
23 this, and if it is legalized I am submitting to you
24 they are going to have it, and that is the problem.

25 Not the kids over eighteen are
26 going to have it, but the problem is under.

27 THE PUBLIC: I'd rather see them
28 using marijuana than glue.

29 I am not saying it's advisable
30 for a thirteen year old to use marijuana.

1 THE PUBLIC: And I would say
2 furthermore, if it was legalized, there would be --
3 you could have much more stringent laws against
4 selling it to minors, and they could be much more
5 easily enforced than they are today.

6 THE PUBLIC: Why?

7 THE PUBLIC: Because a person,
8 a guy twenty years old now who will sell it to an
9 eighteen year old, if he is out for the profit, as
10 some are, he is going to sell it just as easily to
11 a twelve year old because there is no difference in
12 who he is selling to, or no difference in the penalties
13 imposed on him.

14 But you can have a little bit
15 but you can have the same set up as you do with liquor
16 and selling to a minor is a serious offence, whereas
17 ordinary selling to people over twenty-one is not
18 seriously punished.

19 But if you had, say, a legal age
20 of sixteen or eighteen for the smoking of marijuana
21 and said anything under this and you are in real
22 trouble, then there is going to be a large deterrent
23 effect there.

24 THE PUBLIC: Now you are in real
25 trouble if you take them -- and I don't think it
26 would have a deterrent effect on those who would
27 want to take it, because it really isn't all that
28 significant.

29 THE PUBLIC: There is no more
30 deterrent effect from selling it to youth right now,

1 than there is for selling it to somebody forty-five
2 years old.

3 There is no discrepancy in the
4 laws at all, whereas there is a discrepancy in
5 liquor laws.

6 And if you make an even larger
7 discrepancy in modified pot laws then I think there
8 would be quite a strong deterrent effect.

9 Because why run the risk of
10 selling it to someone under eighteen, when you can
11 sell it to someone older.

12 THE PUBLIC: I think, John, on
13 the whole legalization aspect we have got to consider
14 not as much in the view of isolation, rather than to
15 the view of the mere fact that if you do legalize
16 it you are going to control it the same as liquor,
17 and then the government would have the revenue source
18 that they could use for a greater educational purposes
19 as far as drugs go; the national level, say, the
20 drug education centre whereby this would be fed
21 down to various levels, not necessarily governmental
22 levels, but through, say, an independent group. A
23 parallel of the Canadian Federation for Alcohol
24 Treatment, or something like that, and one, say
25 for drug treatment.

26 And the mere fact too, I agree
27 with the point that by having a control system
28 whereby you set an age limit to prevent the sale to
29 minors maybe you could have controls whereby you
30 could keep it out of the hands of organized crime,

1 which is, I think, one of the main things that a
2 lot of people think of, the organized crime, if you
3 believe everything you read in Macleans magazine.

4 THE PUBLIC: Of course, a lot
5 of people who are opposed to it are people who are
6 brought up with it.

7 It is always sort of a vague
8 depravity. Nobody knew about it and nobody wanted
9 to talk about it.

10 You know, like in 1930 with the
11 marijuana tax law in the United States the first
12 Commissioner was Harry J. Anslinger who said one
13 marijuana cigarette could engender a psychotic
14 reaction to a man that would induce him to kill his
15 brother. This is the sort of publicity that has
16 been going on.

17 These posters, one of which I
18 have here somewhere, about beware of the killer
19 drug. When you use the word "drug" a lot of times,
20 the people use the word "killer" with it.

21 Well with penicillin they use
22 the word "drug" but when they talk of marijuana
23 they think of the word "killer".

24 This is a reproduction of an
25 old poster put out by an American agency. It says,
26 "Beware young and old, people in all walks of life.
27 A marijuana cigarette may be handed to you by the
28 friendly stranger. It contains the killer drug
29 marijuana, a powerful narcotic which evolves murder!
30 insanity! death! Warning -- dope pushers are smooth.

1 They may put this drug in a tea pot, or in a cocktail
2 or in a tobacco cigarette."

3 I mean, that is the sort of
4 image a lot of people have, and it is quite under-
5 standable when you are seeing this for fifteen or
6 twenty years, you are not going to question it very
7 much.

8 THE PUBLIC: As far as what, for
9 example we were talking about, the information
10 available, the education for example they mentioned
11 Allied Youth today.

12 I was involved in Allied Youth,
13 and from the type of information that organizations
14 like this put out, and other agencies, is one which
15 is completely negative concerning, for example mari-
16 juana.

17 And what is going to happen is
18 you will have a really hard job telling, for example,
19 me, or telling Jim that marijuana is all bad, when
20 he discovers this information and when he sees I
21 am, for example taking marijuana and tell him how
22 great it is, and not going completely insane or killing
23 my brother, or anything like that.

24 And a much fairer treatment of
25 information, you know would be of much more benefit
26 to the people.

27 THE CHAIRMAN: There are much
28 recognized authorities, like Dr. Joel Forte, who
29 comes out for legalization, and says the A.M.A.
30 report is a lie, and it is very unfounded.

1 DR. LEHMANN: Would you be in
2 favour of having the negative features -- negative
3 potential of marijuana stated too, or would you be
4 in favour of doing what most young people do, only
5 present always the positive and the harmless features.

6 THE PUBLIC: No, I think, you
7 know, what research reveals.

8 For example, Mr. Blanchard's
9 point looked like to me that what happened was the
10 government or executive council decided that, well
11 we don't want marijuana legalized, therefore, you
12 Mr. Attorney General go out and find all the
13 information which will support us, not look at both
14 sides of it.

15 You are going to have a hard
16 time convincing me that marijuana is completely,
17 as he stated in that quote. It's just not true.
18 There is just no research done, except to prove the
19 statement.

20 DR. LEHMANN: That's what he
21 set out to do.

22 Now what we very often hear,
23 particularly from students, is the other side, only
24 how harmless it is, and how good it is.

25 Now would you be in favour of
26 presenting a balanced view, because there is hardly
27 anything in this world that hasn't positive and
28 negative sides to it, or would you be in favour of
29 mostly the positive view?

30 THE PUBLIC: The thing is, I

1 am going to have -- O.K., say I am under the influence
2 of marijuana. I shouldn't drive my car. I have even
3 read that people who take marijuana drive a car
4 very well.

5 I don't know if I could give you
6 from my experience any negative aspects of taking
7 marijuana.

8 DR. LEHMANN: We are not just --
9 but from the scientific literature for instance.

10 THE PUBLIC: I think both sides
11 should be.

12 DR. LEHMANN: Both sides should
13 be.

14 THE PUBLIC: If there are any
15 bad aspects.

16 THE PUBLIC: I would like to
17 know if they can really prove something with the
18 assertions they make against marijuana.

19 I question the validity of
20 these statements. I think it is all a lot of
21 calculated drivel.

22 DR. LEHMANN: Of course that can
23 be said about the positive aspects as well.

24 THE PUBLIC: I don't think so,
25 really.

26 I think really if you had
27 supposing a hundred and fifty marijuana users on
28 P.E.I. for instance, now, and if they all came up to
29 you and said, "I am probably more sane now, or more
30 able to cope with the society now than I was before."

1 I think that is concrete evidence.

2 DR. LEHMANN: That would be.

3 THE PUBLIC: I would submit if
4 there weren't the laws against them coming forward,
5 or if they wouldn't be ostracised or discriminated
6 against when they did come forward, I think you would
7 have concrete evidence to throw out all that bunk
8 that I think a lot of people are throwing around
9 these days against marijuana.

10 THE PUBLIC: One of the things
11 is, we have always had all the negative aspects
12 drilled into us, you know, drug addiction research
13 centres and things like this.

14 And then when you find -- you
15 get talking to people like Dr. J. Robertson Unwin
16 and Kenneth Keniston, and Dr. Mark Segal over in
17 Halifax, and people like this, who really do know
18 more about it than probably anybody else in North
19 America today.

20 And they come out fully in
21 favour of legalization, and of even more than marijuana.

22 Then, you know, it tends to
23 make you realize just what a bunch of, you know,
24 malarky that has been thrown at you by the so-called
25 authorities.

26 DR. LEHMANN: That isn't quite
27 relevant. You see, the question was, should one
28 state what is known, or known to experts of the
29 negative aspects.

30 Now Dr. Unwin, while he has

1 recommended legalization in his brief to the
2 Commission, has also, and is still stating as an
3 expert, that very definitely cannabis can be quite
4 harmful under certain circumstances.

5 THE PUBLIC: Oh, there is no
6 doubt about that.

7 DR. LEHMANN: You would also
8 agree that that should be stated.

9 THE PUBLIC: Oh yes, definitely.

10 But I can see a situation arising
11 where it would be much like alcohol today, where
12 you have groups such as, well, A.A., or the Women's
13 Christian Temperance Society, and various associations
14 and people like this who sort of do the job for society,
15 you know, propagating the negative side of it.

16 But I would prefer to see
17 somebody who would be rather objective about it, and
18 present a list of points for, and points against.

19 THE PUBLIC: You know what
20 might be relevant?

21 If you are comparing alcohol
22 with marijuana -- a lot of people, for instance
23 my parents think that marijuana is much, much more
24 serious than alcohol is, whereas I maintain that
25 in excess both are equally, you know, bad, if
26 you want to call it that, for us.

27 I think that if you really
28 want to get their opinion, I think that an
29 independent study should be made comparing only the
30 bad points only of alcohol and the bad points only

1 of marijuana, and I would submit to you that the
2 bad points of alcohol would at least significantly
3 outweigh the bad points of marijuana. And this would
4 make it relative to them, something they could
5 associate with, you know.

6 THE PUBLIC: I don't think it
7 is easy to use marijuana to excess unless you
8 really set out to do it, because I understand that
9 rather than becoming psychotic you would sort of go
10 to sleep.

11 And rather than on alcohol, you
12 would get drunk and you would keep drinking.

13 DR. LEHMANN: The Commission
14 has talked to some young people who have taken a
15 cube of hashish together with some alcohol, and
16 they were stoned, as they said, for several days.

17 And you know, you might
18 consider that is not a negative effect, but they
19 went out to remain stoned for several days, and
20 that can comparatively easy be done by simply taking
21 a cube or two of hashish.

22 THE PUBLIC: Then again, that
23 is a bit different from marijuana. You could,
24 I imagine, swallow an ounce of marijuana and get
25 a similar effect.

26 You would really have to set
27 to do it, rather than ---

28 DR. LEHMANN: Oh yes.

29 THE PUBLIC: I think it is much
30 more easier to sort of get above yourself with

1 alcohol when you sort of forget how many drinks
2 you have had, sort of thing.

3 DR. LEHMANN: That I can't
4 quite see the reasoning in.

5 If you set out to get drunk
6 on alcohol you have to set out -- you know, you have
7 to pay for it, and if you set out to get stoned
8 on marijuana or hashish you set out to get stoned ---

9 THE PUBLIC: I am not saying
10 that. I am just saying it is easier if someone
11 wanted to have, say, a few drinks, or have a
12 marijuana cigarette, I think it would be more
13 easily for a person to take a few more drinks,
14 take a few more drinks than it would be to take a
15 lot more marijuana than he would intend.

16 PROFESSOR BERTRAND: Coming back
17 to what you call the communal value effect of the
18 taking of marijuana, would it be right to say --
19 supposing you go to a cocktail party -- it may be
20 really a very conformist way of defining sociability
21 of the drug.

22 Well, you see people talking
23 to each other more than they would do, say at
24 their work. You see people attempting to some
25 point -- looking at each other -- even attempting
26 to make gestures of tenderness or affection; whereas
27 during some pot parties. I rather saw people not
28 communicating in any fashion. Am I right?

29 THE PUBLIC: What do you mean
30 by communicating? Like just lying there listening

1 to music can be a form of communication.

2 PROFESSOR BERTRAND: This is why
3 I said conventional.

4 THE PUBLIC: You don't have to ---

5 THE PUBLIC: Communication isn't
6 strictly verbal.

7 THE PUBLIC: Just holding hands
8 can be a form of communication.

9 PROFESSOR BERTRAND: Well, they
10 weren't holding hands.

11 THE PUBLIC: What exactly were
12 they doing?

13 PROFESSOR BERTRAND: Nothing
14 that you could see.

15 THE PUBLIC: Nothing that
16 you could see. When you get down to actually getting
17 high on marijuana, usually what is done, people
18 sit around in a circle and pass the same cigarette
19 and they make another cigarette, whereas people
20 sort of bring their own bottles to a party, and
21 drink out of their own bottle. They don't usually
22 drink out of the same glass, usually.

23 THE PUBLIC: It is sort of
24 a ritual. I would think, in a way.

25 PROFESSOR BERTRAND: Would
26 you agree, though, on the definition of communication
27 which would mean that at some point the receiver of
28 the communication has to be aware that something
29 is communicated to him?

30 THE PUBLIC: I believe there

1 is a different language being used in communication
2 that we are not maybe into, and the basic thing is
3 called "vibration".

4 Instead of having to speak and
5 make all the gestures that you call them trying
6 to be friendly, there are vibrations that go through
7 the mood and everybody feel them, and you move with
8 them, and you don't have to talk.

9 PROFESSOR BERTRAND: I am
10 questioning everybody because there certainly are
11 pot smokers who do not get vibrations.

12 THE PUBLIC: You are suggesting
13 ten people lying around in a room, or five people,
14 listening to music are communicating.

15 I rather think it is a very
16 individual experience.

17 THE PUBLIC: I think it is
18 individual to be with other people too. There seems
19 to be less phoniness or something, than with alcohol.

20 A group of people who decide
21 to smoke pot usually go as an intimate group to
22 start off with, because first of all it is illegal
23 and things like that.

24 THE PUBLIC: Are you a different
25 person when you are on pot, if in fact you ever were?

26 I realize the question wasn't
27 very well put.

28 Would you consider a pot person
29 a pot smoking person under the influence of marijuana,
30 for instance, different than he is when he is not?

1 THE PUBLIC: I think it has a
2 lot to do with the individual but also I think
3 it is a greater sensitivity, as he described, a
4 communication ---

5 THE PUBLIC: If there is no
6 difference I wouldn't take it.

7 THE PUBLIC: One or the other
8 has to be the real person. One or the other has to
9 be the real person, and I don't simply buy this
10 business of phoniness.

11 THE PUBLIC: It sounds like
12 you are saying each person has only one set way
13 to be real.

14 THE PUBLIC: No, I am saying
15 I don't necessarily think that smoking pot makes
16 you a genuine person.

17 THE PUBLIC: It doesn't necessa-
18 rily.

19 THE PUBLIC: You seem to be
20 suggesting that it reduces the phoniness.

21 THE PUBLIC: It heightens my
22 sensitivity, and awareness, and communication with
23 other people the whole feeling of warmth radiating
24 from people and objects in the room, things like
25 that.

26 Yes, I would say by degrees I
27 am a very level person.

28 THE PUBLIC: Then you are phony
29 now, then, is this it?

30 THE PUBLIC: Not necessarily

1 phony.

2 THE PUBLIC: He is talking
3 relatively obviously.

4 THE PUBLIC: That doesn't
5 mean I am phony now.

6 THE PUBLIC: If there are
7 certain things that make you more sensitive. does
8 that mean you are insensitive now?

9 THE PUBLIC: Yes, it could be.

10 DR. LEHMANN: Do you say
11 temporarily only while you are smoking or for good?

12 THE PUBLIC: It's not doing you
13 any good if it's temporary.

14 THE PUBLIC: That's not true.
15 Just because it is right then ---

16 THE PUBLIC: I am taking a
17 breath temporarily, but it's doing me a lot of
18 good.

19 Am I going to hold it and go ---

20 THE PUBLIC: You missed the
21 point, obviously.

22 DR. LEHMANN: You just said
23 you are not a person now.

24 Do you mean because of marijuana
25 one may become another person, and stay that way
26 less phony, or do you just mean you are less phony
27 while you are under the influence of the drug?

28 THE PUBLIC: I don't think
29 the change is that drastic.

30 THE PUBLIC: I think it could

1 change.

2 THE PUBLIC: Sudden change.

3 THE PUBLIC: I said it doesn't
4 have the phoniness that alcohol has got in trying
5 to relate to other people.

6 It seems then to become very
7 phony to me.

8 THE PUBLIC: I think another
9 thing, if marijuana can induce a feeling of
10 relaxation, it is worth while only and perhaps
11 new sensitivities, it is worth while only that you
12 profit from that experience and that gradually you
13 move away from meeting the sensitivity awareness
14 that you are getting through marijuana.

15 If all you are getting is a
16 drunk on alcohol and a high on marijuana and
17 nothing else after that, then I think it is a waste.

18 THE PUBLIC: Why?

19 THE PUBLIC: I think it is
20 a real sham. You know, I think we should learn
21 from these experiences.

22 THE PUBLIC: What if you read
23 a book, what does that do?

24 THE PUBLIC: You learn from
25 it.

26 THE PUBLIC: You learn from
27 it.

28 THE PUBLIC: And it is with
29 you afterwards.

30 THE PUBLIC: And the question

1 you say about the changes in a person -- how many
2 books have you read in your life?

3 THE PUBLIC: Lots of them.

4 THE PUBLIC: Which one, in
5 what way?

6 THE PUBLIC: There is a
7 sudden change here, John.

8 What I am suggesting here is
9 if you ask does it last afterwards, of course it
10 does last.

11 THE PUBLIC: It lasts afterwards?

12 THE PUBLIC: In a sense. Not
13 in the sense that you are goint to be stoned
14 permanently or something.

15 THE PUBLIC: Then you profit
16 from the experience?

17 THE PUBLIC: Yes, I am sure,
18 positive.

19 THE PUBLIC: And you become
20 more sensitive afterwards, and gradually you can
21 get all the good things from being high by not
22 being high, actually.

23 THE PUBLIC: Well, I don't
24 know if that is going to happen I can't predict
25 that, but I am saying even if I only compare when
26 I was high and now, then that was the lasting effect
27 on me because I can remember.

28 Like when you are stoned drunk,
29 you know, people start telling you what you did that
30 night.

1 But with marijuana you can --
2 you remember and you can feel these things over
3 and over again sometimes.

4 Like sometimes you can just
5 be sitting around the room yourself, you can sort
6 of realize and relate back to that, and it makes
7 you happier and shows you how sensitive you had
8 been, and in the communication that is going on.

9 Yes, I think it is a definite
10 value. Although, you are trying to present here
11 that you reach a permanent high all the time.

12 THE PUBLIC: I think this is
13 really one of the redeeming factors that I had
14 been going under the assumption that many people who
15 had smoked pot become more sensitive and perhaps
16 even more artistic, in respect to things.

17 THE PUBLIC: Definitely.

18 THE PUBLIC: That's about the
19 only good thing.

20 THE PUBLIC: (Portion unintelli-
21 gible)

22 I don't think you are going to
23 get stoned and create a great work of art.

24 THE PUBLIC: I am not suggesting
25 that. I am suggesting you could appreciate art
26 and things like that.

27 THE PUBLIC: The act of doing
28 it once is of benefit to you.

29 THE PUBLIC: If you could go
30 down to the gym and play basketball your blisters

1 aren't going to last forever, but do you feel it
2 is of no value to play basketball?

3 THE PUBLIC: I think we are
4 arguing two different arguments.

5 THE PUBLIC: Every person has
6 a different feeling I think for marijuana.

7 It was with alcohol you said
8 people sit around and talk. Some people are really
9 you know, turn into animals when they start drinking,
10 and get drunk.

11 DR. LEHMANN: And you are
12 never ashamed of a marijuana experience?

13 THE PUBLIC: No.

14 THE PUBLIC: If someone is
15 depressed and they smoke marijuana it is not going
16 to -- it is just going to sensitize the depression.

17 It is a sensitizer. It is not
18 going to make them happy.

19 DR. LEHMANN: Can you ever be
20 ashamed of a marijuana experience, as you are with
21 alcohol apparently?

22 THE PUBLIC: Sure you can.

23 THE PUBLIC: I imagine you could.

24 THE PUBLIC: Well, it is
25 probably within the realm of possibility.

26 THE PUBLIC: Something that
27 you say to people.

28 DR. LEHMANN: On the marijuana?

29 THE PUBLIC: Yes.

30 DR. LEHMANN: But you are

1 suppose to be more sensitive?

2 THE PUBLIC: You could say
3 something to people, and you know, realize at the
4 moment that it was really a bad thing to say. On
5 marijuana you realize this, you would be a lot more
6 sensitive to what you said, and you really feel
7 it inside you.

8 THE PUBLIC: The only bad things
9 I have ever heard is when other people who are
10 not with me, and started saying things to you,
11 and you sort of lose contact with the group and
12 the community feeling and things like that.

13 THE PUBLIC: What sort of
14 feeling?

15 THE PUBLIC: Oh, something like,
16 "The cops are coming."

17 Or more people coming and
18 knocking at the doors. For example, I took
19 marijuana and went to see Easy Rider, and I got very
20 depressed, you know, I was very depressed.

21 When it was starting out I was
22 so happy, and I really enjoyed it, I could really
23 feel myself being uplifted by them taking off across
24 the border and they were very happy, and I felt very
25 happy and at the end I ended up feeling very
26 depressed.

27 I was much more sensitive to
28 this.

29 PROFESSOR BERTRANL: The
30 story is not particularly happy.

1 THE PUBLIC: In the beginning
2 it is very happy, and at the end they both got
3 shot.

4 I think I was more depressed
5 than if I hadn't been taking marijuana.

6 But the thing is afterwards
7 I got much more meaning from the show, and I
8 related to it much better because of this, much
9 better if I had just gone and watched the show.

10 THE CHAIRMAN: How do you
11 mean you related, because there had been a
12 heightening of your experience, but that is not the
13 experience you would have had -- sensitive involvement
14 you would have had if you hadn't been high when
15 you were watching it.

16 Now why -- how do you feel that
17 that is a more significant experience because it is
18 not the normal -- it is not the way one has to
19 relate to the general rule of two things.

20 THE PUBLIC: I feel people
21 should be much more sensitive.

22 PROFESSOR BERTRAND: Should
23 do it more? You mean you have tried both, you have
24 seen the picture twice?

25 THE PUBLIC: No, but I have
26 seen several pictures.

27 PROFESSOR BERTRAND: But you
28 still could compare.

29 THE PUBLIC: I think I still
30 could compare.

1 THE CHAIRMAN: Here is an
2 interesting thing. Don't you feel that a person
3 could be deeply moved and involved in a work of
4 art, without this?

5 I mean, isn't this a reflection
6 of the personal capacity for being moved, and
7 being deeply impressed?

8 THE PUBLIC: If I may answer
9 you on that one, I believe that we are talking
10 about expansion here, I think that is the term.

11 When we get into motion in
12 this expansion you miss so many things the first
13 time, and where Dennis is talking about marijuana
14 for Easy Rider, he can bring in -- he is capable
15 of seeing more things because his mind is working
16 on a different level.

17 His normal mind hasn't been
18 removed. He has seen the movie on that level,
19 and he is also changing into another level.

20 But he is opening up a new
21 field.

22 THE CHAIRMAN: Well, what is
23 it that marijuana does that permits this release,
24 or expansion that we should not otherwise be
25 capable of enjoying?

26 THE PUBLIC: All right. If
27 you want to study a picture, a work of art
28 (painting) or if you want to study a poem or
29 listen to a song, you have to concentrate on that
30 and it requires a form of meditation, a preliminary

1 form where you get to the point where you can come
2 to an understanding with this, and marijuana helps
3 to enhance that.

4 It brings it around possibly
5 a bit faster and opens it up a bit wider.

6 THE CHAIRMAN: Don't you think
7 that we are meant to have this natural capacity
8 for a high? What is that is preventing the whole- /
9 hearted involvement, this wholehearted apprehension
10 of life, of meaning of significant. What is it that
11 the poet has but he doesn't need marijuana?
12 What is it the musician has that he doesn't need
13 marijuana, or the artist.

14 THE PUBLIC: We are generalizing
15 here, because I think sort of because of the
16 rush society we have with the goals or the values
17 which our society has which we really can't
18 relate to people.

19 PROFESSOR BERTRAND: Even
20 here in Prince Edward Island?

21 THE PUBLIC: Yeah, even here
22 in Prince Edward Island, the experience of
23 touching people, you know, if for instance if a man
24 comes and sits down beside me I will consciously
25 move over, sort of thing, you know, that happens,
26 sort of this fear of touching people.

27 Well under marijuana, I don't
28 think you have that. I feel you don't have this
29 fear of touching, and being outgoing and honest
30 which in many cases, for some reason people

1 just don't communicate in that way in our type
2 of society.

3 THE PUBLIC: So marijuana
4 helps you overcome your basic hang ups, your
5 basic hang ups.

6 THE PUBLIC: Yes, I think it can.
7 Well personally for me it does help.

8 THE PUBLIC: For a time.

9 THE PUBLIC: No, John, I
10 already answered that before in relation -- you know,
11 even if you only relate back to that.

12 So its an ongoing thing too.

13 THE PUBLIC: I would like to
14 make a point that I don't think marijuana is going
15 to make you do anything you couldn't do without it.

16 I just think it would sort of
17 release you so you would look at things more closely
18 maybe, or you will be more attuned to things, whereas
19 you would maybe pass by ordinarily.

20 I am not saying that you
21 couldn't, you know, if you want to stop and
22 concentrate and get involved in something you could
23 do it.

24 Anyway, I would just say it
25 is an easier way to do it and you are not going
26 to go, you know, way beyond your capabilities.

27 THE PUBLIC: Marijuana is not
28 really that strong. It is pretty mild. It is not
29 stronger than alcohol.

30 I mean the degree of an

1 alcohol down is probably the extent of a marijuana
2 high.

3 THE PUBLIC: You are not
4 comparing the effects, are you?

5 Are you saying the effects are
6 the same?

7 THE PUBLIC: No, I am saying
8 the degree.

9 THE PUBLIC: O.K.

10 THE PUBLIC: Marijuana isn't
11 a very strong drug, you know, I happen to like
12 drinking a beer quite a bit. And I don't know
13 I think I get high on beer, and I think you are
14 turning too much to this drug, and also to
15 marijuana and appreciating art and creativity.

16 I can't think of any -- you
17 know, any work of art that I particularly enjoy
18 that comes as a result of a drug experience.

19 And particularly if I know
20 it comes from a drug experience I shun it. I don't
21 like it too much.

22 THE PUBLIC: Jim, you said
23 that we are all capable of doing this -- of experienc-
24 ing these things although we haven't got the time
25 really to do it.

26 THE PUBLIC: I didn't say we have
27 the time.

28 THE PUBLIC: You are saying we
29 don't. I don't know whether the time ---

30 THE PUBLIC: So you say

1 marijuana allows us to appreciate one thing. O.K. ---

2 THE PUBLIC: Not necessarily
3 one.

4 THE PUBLIC: To appreciate
5 things that we ordinarily wouldn't appreciate,
6 because we are in a rush.

7 THE PUBLIC: Rush means our
8 whole society.

9 THE PUBLIC: So marijuana is a
10 stop-gap measure. It is not the solution to the
11 problem, is it?

12 It allows us to solve the
13 problem temporarily while we are on a high, but
14 it doesn't solve the problem of our rush, rush
15 attitude, and our inability -- you are saying we
16 don't have an ability to experience these things,
17 only marijuana allows us to devote enough of our
18 sensitivity for a time you know, promotes a
19 sensitivity thing for a while.

20 So in other words, you are
21 saying we are capable of it, we are going so fast
22 that occasionally we have to have marijuana to
23 slow down to appreciate something.

24 I am saying the basic problem
25 is we are rushed, rushed and to solve that problem --
26 if we solve that problem we won't have to have drugs
27 or anything like that, will we?

28 You say we are capable of it
29 without drugs.

30 THE PUBLIC: I am not blaming

society necessarily, I am blaming maybe people themselves.

If you are on a desert island or something wandering around, you still might not concentrate, you know there is no rush if you had plain food and you still might not concentrate that much.

I am not blaming it entirely on technology.

THE PUBLIC: What I am suggesting is, going by your promises, we are all capable of these things without drugs, if you slow down and you appreciate them and then the basic problem of alcohol and drugs, everything could be solved if we could find out how to slow down our whole society and to reorganize in such a way so people can exist without having to go to drugs, booze and everything else to appreciate it.

THE PUBLIC: That's possible.

THE PUBLIC: There are other things, too.

How many people have ever listened to Trees?

I don't want to get into this.

THE PUBLIC: He does.

THE PUBLIC: All right.

THE PUBLIC: And he is talking.

THE PUBLIC: I am saying that

I don't ---

THE CHAIRMAN: Is that listening

1 to the wind going through the trees, or does it mean
2 to trees growing?

3 THE PUBLIC: Closer to listening--
4 Leonard Cohen said one time you can hear branches
5 screaming when you pull them out of the ground. Well,
6 anyway, it is almost closer to sort of seeing, or
7 feeling, or hearing them growing and I don't think --
8 I am not capable really of doing that today right
9 now, but I have done it.

10 And I might be mystical or
11 what, but for some reason I was able to do that.

12 THE PUBLIC: But Dennis, if
13 you were alone someplace and you were relaxed, and
14 you didn't really plan on going anyplace, and you
15 sat down and just very relaxed and looked all
16 around you, took the time, because you had the
17 ability to do it if you just take the time, I think
18 you can hear the trees.

19 THE PUBLIC: I think it is
20 inherent ---

21 THE PUBLIC: If you wanted to
22 concentrate.

23 THE PUBLIC: If you wanted to
24 concentrate.

25 THE PUBLIC: I don't know whether,
26 in this day and age, if people can really relax,
27 truly relax.

28 It is very few people that
29 can reach that type of high, and it is very few
30 people that can do that themselves, completely

1 relax and let go.

2 I don't think people can do that.

3 I don't know whether I can. It might be inherent
4 in me.

5 But with all the restrictions ---

6 THE CHAIRMAN: I recognize you.

7 THE PUBLIC: Don't you think
8 people in society today are afraid to be alone?

9 Even if we are at home we can
10 turn on the radio. You know, we don't give
11 ourselves a chance to be alone, and a chance to think
12 about these things.

13 There always seems to be other
14 things interrupting, such as a radio, T.V., what
15 have you.

16 PROFESSOR BERTRAND: What in
17 relation to drugs?

18 THE PUBLIC: He was saying
19 the sensitivity, it brought on a particular
20 sensitivity.

21 Well I think it is in many ways
22 perhaps psychological, because if you take something
23 that you think is going to make you ill, you know,
24 immediately you are feeling ill and I think that
25 with the drugs it is perhaps true, you think you
26 become more sensitive, but do you really?

27 Don't you think you just feel
28 you are taking something, and it is supposed to make
29 you sensitive, therefore you start thinking more along
30 these lines.

1 THE PUBLIC: What is the
2 difference?

3 THE PUBLIC: Well, I am saying
4 that it is not necessarily the drug.

5 THE CHAIRMAN: Is it possible
6 that you can pay a certain price for developing
7 this sensitivity, or capacity for emotion expression?

8 I mean is it possible that one
9 could end up paying a certain price, in terms of
10 ones intellectual and analytical capacities which
11 are also part of the total function of a human being,
12 in other words the emphasis is feeling, the
13 emphasis on developing this. Is it possible we
14 could pay a price in the diminution of the clarity --
15 cutting edge of mind, which is also ---

16 PROFESSOR BERTRAND: I don't
17 think that Mr. LeDain is saying that we are not
18 ready to pay the price, only that are we aware!

19 THE CHAIRMAN: Do you consider
20 the possibility in the artificial development of this
21 other thing.

22 THE PUBLIC: Sure.

23 DR. LEHMANN: Would you be
24 prepared to pay that price?

25 THE PUBLIC: I don't know
26 what -- I would have to know what the price was
27 first.

28 I see the world as it is
29 today, you know, we are living on the brink of
30 destruction right now.

1 I think a lot of kids believe
2 this. It is just really "live for today" because
3 of the problems we are having.

4 THE PUBLIC: And because they
5 can't control their futures because of these
6 problems?

7 Would you be saying that too?

8 THE PUBLIC: Not really.

9 Yes, in some way, I suppose.

10 THE PUBLIC: This all gets
11 back then, if you can't find yourself in society
12 if you can't relate to society because it controls
13 your future, you go within yourself to find
14 yourself, or to relate to yourself, because you
15 can't do it within the society.

16 Would you agree with that,
17 David?

18 THE PUBLIC: You take the
19 drugs to find yourself?

20 THE PUBLIC: I hate to use
21 that expression because everyone thinks it is
22 immature.

23 I happen to disagree with it
24 being immature. I don't think it is immature to
25 want to find yourself I think it is quite mature.

26 What I am trying to say is a
27 lot of kids turn to drugs because they realize they
28 have got to live for now, because there really isn't
29 much future.

30 Then you are admitting you

1 can't really do much about my future in a sense.
2 you go withinin your self and you have artistic
3 experiences and things like this.

4 THE PUBLIC: I know I could do
5 something better but whether it will do any good or
6 not to the whole situation ---

7 THE CHAIRMAN: I am sorry. I
8 regret -- I shouldn't say I regret, because we
9 have benefitted a great deal by all of our
10 public hearings, and I am sure we will this afternoon,
11 but I really regret that we have to go.

12 We promised to be back at 2:30.
13 This has been a very, very fine exchange of views for
14 us, and we should really comment -- try not to make
15 comparisons. but I would just like to say to the Dean,
16 from our short impression here. I personally
17 speaking for myself was very impressed by the atmos-
18 phere that you have in this university.

19 Whatever you are doing, Dean,
20 is pretty good.

21 Thanks very much.

22
23 --- Upon adjourning at 2:24 P.M.
24
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